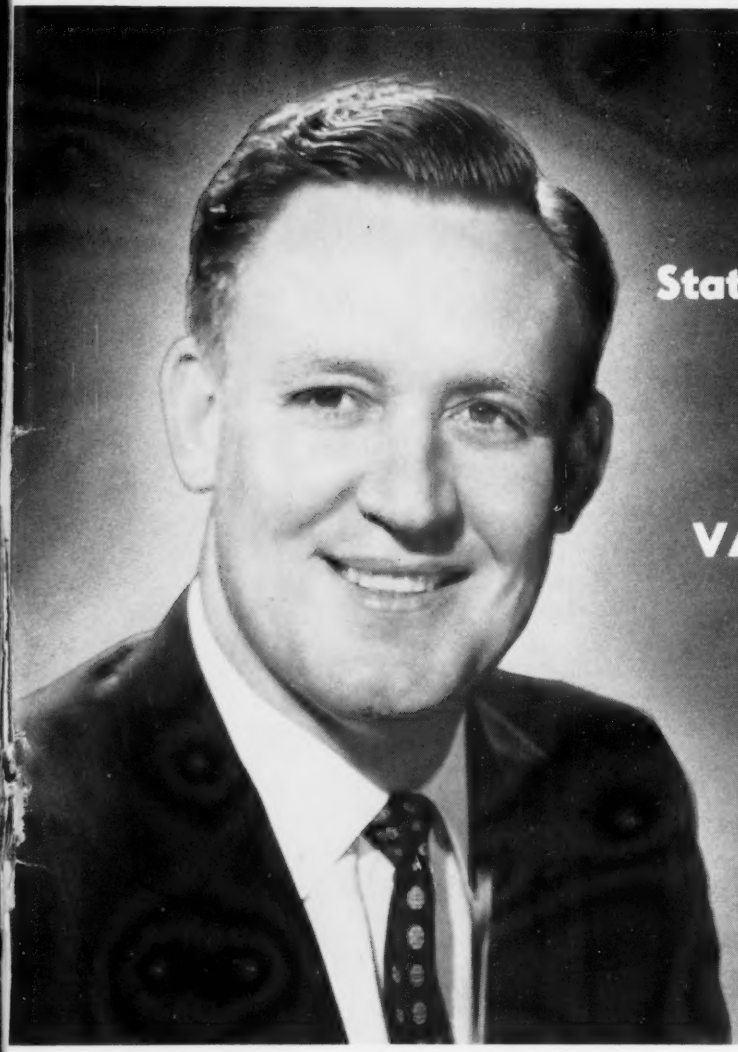
HOSPITAL Topics

THE NEWS MAGAZINE FOR HOSPITALS



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GENE KIDD (see page 3)

A. M. A. Scientific Exhibits
Picture Report—Center Section

AUGUST | 1955

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2. U. S. Public Health Service, Division of Hospital Facilities and Division of Medical and Hospital Resources.

3. Richard Malachowski, chief architect, Lima, Peru.

4. Edw. D. Stone and A. L. Aydelott, Associated Architects.

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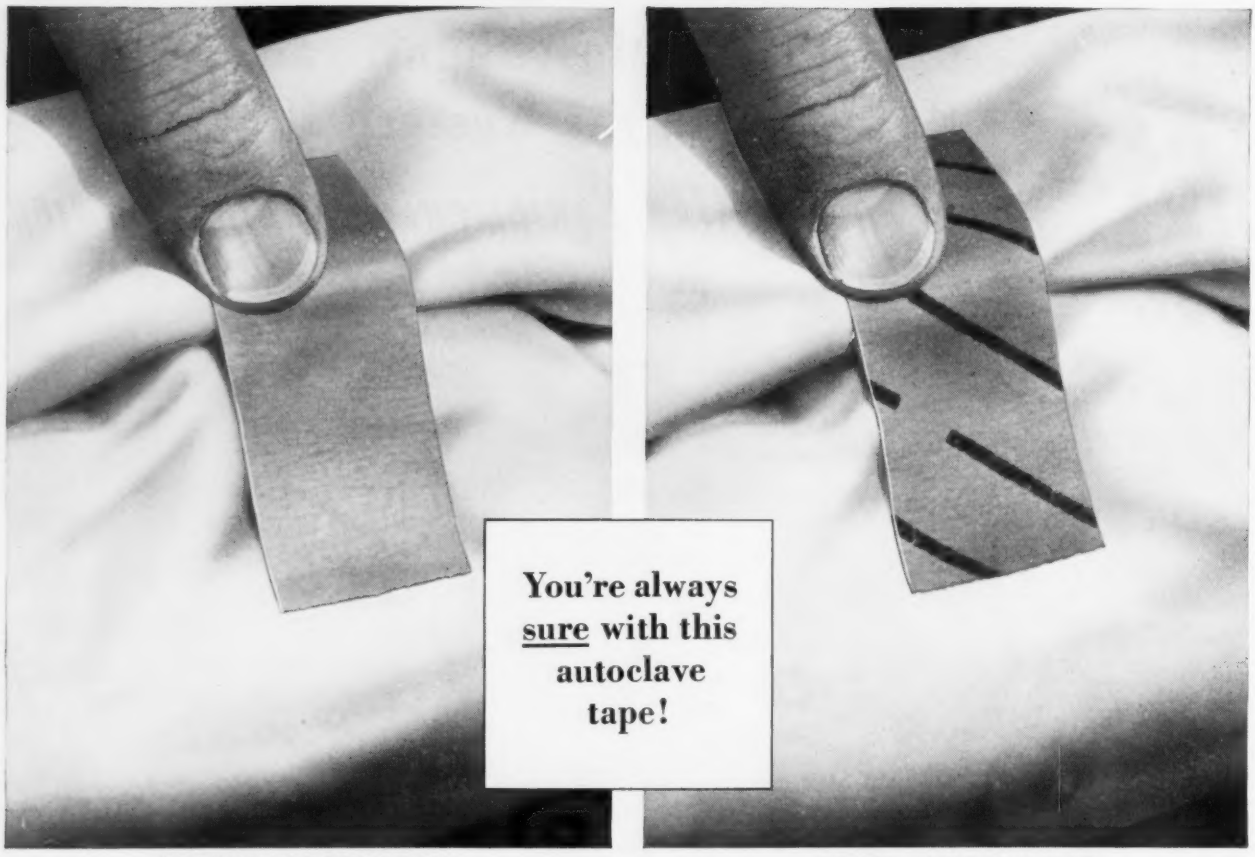

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HOSPITAL Topics

The News Magazine for the Hospital Staff

AUGUST 1955, VOL. 33, NO. 8

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PERSONALITY OF THE MONTH

For a man not quite 35 years old, Gene Kidd has acquired an impressive record in the field of hospital administration and community affairs. Presently administrator of Baptist Hospital, Nashville, Tenn., Mr. Kidd began his career as assistant executive secretary of the Virginia Medical Service Association, Richmond. From there he went to Albany, Ga., where he became administrator of Phoebe Putney Memorial Hospital. In his present position in Nashville, he is in charge of the 250-bed institution plus a school of nursing which has 100 students.

Mr. Kidd

Active in hospital affairs, Mr. Kidd is a past president of the Georgia Hospital Association, was a Georgia delegate to the 1951 convention of the American Hospital Association, is a member of the Southeastern Hospital Conference and the Tennessee Hospital Association, and is a nominee of the American College of Hospital Administrators.

Young Mr. Kidd's "past" extends to community affairs. He is a past president of the Lions Club of Albany, Ga., past president of the Junior Chamber of Commerce, Albany, and past vice-president of the Georgia Junior Chamber of Commerce.

He is married and has two children. He was educated at William and Mary College and Washington and Lee University. His hobbies are golf, hunting, and officiating at high school and college football games.

For Patient Protection

The Posey Safety Belt

Standard Model: S-141, $6.00. Extra-heavy model: P-453. Riveted construction with keylock buckles, $18.50 each. Prevents patients falling or getting out of bed.

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prescription pad

Otamylon Ear Drops

Otamylon Ear Drops, a new product effective against all commonly encountered ear pathogens, has been introduced by Winthrop-Stearns, Inc.

The compound also has a local anesthetic and dehydrating effect that soothes irritated and inflamed surfaces of the ear and hastens healing. The manufacturer says the drops are indicated for topical use in acute and chronic otitis externa, furunculosis, otitis media, and following mastoidectomy and fenestration operations.

Otamylon is a clear, sterile, viscid liquid containing 5 percent sulfamylon hydrochloride and 5 percent benzocaine propylene glycol.

In clinical tests, Otamylon cured 76.7 percent of 462 patients with otitis externa, otitis media and furunculosis in less than seven days. An additional 12.3 percent were cured in less than 14 days. In acute and chronic otitis externa, the compound rapidly relieved pain, combatted the infection, and maintained the skin's normal acid state. The pain and infection of furunculosis and dermatitis of the ear were similarly controlled.

Otamylon Ear Drops are supplied in bottles of 15 cc. with dropper.

Peripheral Vasorelaxant

Arlidin is a pharmacologically active drug which affords rapid and prolonged vasodilatation and vasorelaxation, and alleviates blood vessel spasm to increase peripheral blood flow and furnish oxygen to distressed muscle tissue.

The compound relieves pain and numbness of extremities, increases walking ability, restores warmth and color to feet, legs and hands, allays nocturnal cramps, helps prevent and heal ischemic ulcers . . . in intermittent claudication, diabetic vascular disease, Raynaud's disease, thromboangiitis obliterans, thrombophlebitis, endarteritis obliterans, ischemic ulcers, diabetic gangrene, frostbite and night leg cramps.

Arlidin increases blood flow largely to muscles where it is most needed in claudication. It improves peripheral blood flow by increasing rather than decreasing cardiac blood flow and with little or no lowering of systolic blood pressure.

The oral dosage is one tablet three or four times a day or more as required (with an additional tablet at bedtime for night cramps); parenterally, 0.5 cc. subcutaneously or intramuscularly to start, increasing gradually to 1 cc. one or more times daily as needed.

There is a wide margin of safety between therapeutic and toxic doses. Nervousness or palpitation may be observed in occasional patients but this is rare with low initial dosage. Use cautiously in hyperthyroidism, paroxysmal tachycardia and severe angina pectoris. Contraindicated in acute coronary thrombosis.

Arlidin is supplied in tablets, 6 mg. (scored), bottles of 50, 100 and 1000; and as Arlidin Parenteral, 5 mg. per 1 cc. ampul, boxes of 6, 25 and 100 ampuls.

New Topical Preparation

Tronolen Lotion, a new topical preparation from Abbott Laboratories, has three distinct actions: anesthetic, antihistaminic and antipruritic properties. It is neither greasy nor chalky and becomes almost invisible after it is applied.

Tronolen contains Tronothane Hydrochloride (1 percent) and Di-Paralene Hydrochlorides (2 percent). It is indicated for relief of surface pain or itching in various dermatoses, pruritic syndromes, minor burns or sunburn, poison ivy, oak or sumac, insect bites, athlete's foot, abrasions, chafing, diaper rash and scalds.

Recommended administration is three or four times daily or as directed by the physician. Prolonged use or application to extensive areas of the body is not recommended. Tronolen is supplied in 75-cc. plastic squeeze bottles.

New Analgesic-Antacid

Falgos Tablets, a new buffered analgesic compound tablet has been introduced by American Ferment Co., Inc.

The new compound is indicated for the relief of pain in headache, neuralgia, neuritis, muscular aches, the common cold, and following dental procedures and extractions. It is effective, also, in treating the minor pains of rheumatism and arthritis.

Falgos is supplied in bottles of 15 and 40 tablets.

clinical notes

Treatment of Parkinsonism

The new compound, Parsidol, has proved a valuable agent in Parkinson's disease, according to a report in *Neurology* by Ziegler and Torres of Montefiore Hospital, New York City. The authors found that tremor and limb stiffness were noticeably reduced in 13 of 17 patients who received the new drug.

The report deals with 30 patients, most of whom were already receiving other drugs and were being treated as outpatients.

Thirteen of the patients were eliminated from the study because they reacted either favorably or unfavorably to placebos, on which all the patients were started.

After these more suggestible patients had been eliminated, the drug was substituted for the placebos without the knowledge of the patients or of one of the two physicians.

The report states that subjective response proved to be a reliable clue to drug effect, either beneficial or not. In 10 of 12 patients reporting subjective improvement, objective improvement was found on examination. Such factors as rigidity, tremor, facial expression and gait were watched by the investigators for signs of improvement.

The new compound seems to be a useful addition to the drugs available to patients with Parkinsonism, since 13 of 17 fairly reliable patients showed some degree of improvement in tremor or rigidity or both. It is emphasized that the changes are rarely striking and that this medication, like all others used for patients with this condition, is most effective in combination with other drugs.

Use of Trypsin

When it is desirable to concentrate antibiotics in the spinal fluid, as in the treatment of spinal meningitis, trypsin may be an effective way of getting it there without injecting directly into the spine.

Martin, Beiler, and Moss, of Philadelphia, reported before the recent meeting of the Society of American Bacteriologists on experiments that raise this possibility.

Penicillin was given intramuscularly in therapeutic doses to animals, with and without trypsin. Where penicillin was given alone, antibiotic level in the spinal fluid stood at 0.45 micrograms per milliliter two hours after injection, and then fell rapidly, registering only 0.27 micrograms another hour later.

In the animals also getting trypsin, spinal tap at the second hour showed a penicillin level of 0.81 micrograms, and it increased thereafter, reaching 1.06 micrograms at the third hour.

Whether this finding can be useful in treating human infections remains to be seen, the authors emphasized. Tests with humans are now under way.

Leukorrhea Therapy

Excellent results in vaginal leukorrhea with Milibis administered in the form of vaginal suppositories, are described by Shanaphy, of the New York University College of Medicine, in the New York State *Journal of Medicine*.

The drug was used by 510 patients with symptomatic leukorrhea caused by trichomonad, monilial or mixed and bacterial infection. The total dose per patient was five suppositories, given on alternate days. Of 169 cases of trichomoniasis, 77.5 percent were completely relieved by one course of therapy, while only 11 patients, 6.5 percent, failed to improve. An additional 16 percent in the group were improved by the first course, and many were completely relieved at the end of the second series of treatments.

In the group of 182 cases with monilial infection, 75 percent experienced complete relief of symptoms, and 21 percent moderate relief, following the first course of treatment. The tests also showed 73 percent of the 159 cases of mixed and bacterial infection to be asymptomatic, and 20 percent moderately abated, after the first course.

Side effects were extremely rare among 88 percent of the 510 patients who were given follow-up examinations.

The author reported that 10 patients experienced burning and itching sensations, which completely disappeared without the use of any medication 24 hours after therapy was discontinued.

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HOSPITAL Topics
The News Magazine for the Hospital Staff

VOL. 33, NO. 8
AUGUST 1955

Scanning the News

Better to be Conceived In Cool Months

If you were conceived in July, August, or September, and didn't make "Who's Who," you'd better forget it, Clarence E. Mills, M.D., director, laboratory for experimental medicine, University of Cincinnati, told a Chicago group.

Studies show that children of summer pregnancies have only half the likelihood of entering college. The "Who's Who" volume, he said, is "practically reserved" for those conceived in the coolest months of the year.

The problem is that of getting rid of body heat. Humans convert only about 25 per cent of fuel intake into useful energy. The rest is given off as heat. In hot weather it is harder to get rid of body heat.

As heat loss slows down, our body cells become affected, he said, including the germs cells involved in reproduction.

Aspirin Boxes Should be Marked

All packages containing aspirin, or other salicylate compounds should bear a warning, "keep out of the reach of children," according to the Committee on Toxicology of the AMA.

The report adopted by the committee also recommended that the table should state "Consult your physician on dosage for children under three years of age."

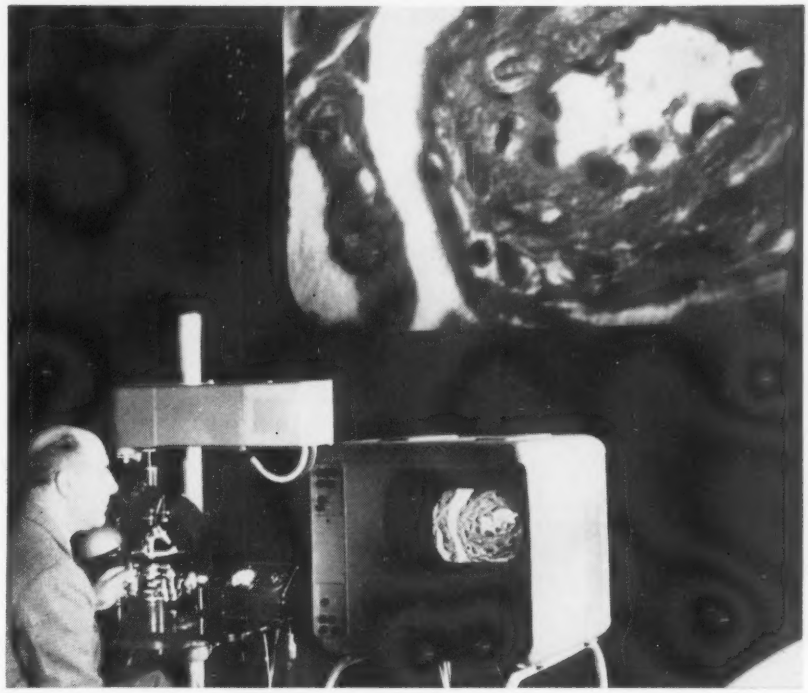
They also said that individual pills should be wrapped in metal or plastic foil that can't be easily removed by children.

Of the 113 deaths in the United States known to have been caused by salicylate compounds in 1952, 86 occurred in children under five years of age. Forty-one of these were caused by aspirin, the report said.

Parakeets and Eels Used in Cancer Study

Parakeets and eels are being studied at a cancer research project at Ohio State University. The parakeets are being watched in the hope of finding clues to the cause of pituitary gland tumors which they are particularly likely to develop.

Because eels secrete from their mouths a substance which keeps blood from clotting, they are being studied to see what effects this secretion has in the treatment of leukemia and other blood diseases.



The new electronic color microscope system was demonstrated at the recent AMA meeting in Atlantic City. Pictured above on the large screen are cancerous tissues magnified 15,000 by the CBS laboratories system. At the bottom of the picture is the tissue as it appears on a small screen. The microscope proper is displayed at the lower left.

Parking Lot Control System in Effect

Electronically operated parking lot control systems have been installed in 23 hospitals throughout the country to assure parking space for doctors and other selected hospital personnel.

Only persons furnished with special metal-impregnated cards, which actuate gates controlling entry and exits, have access to the lots. Since the lots are mechanically operated, there is no need for attendants. A small charge is made by the hospitals for the parking privilege.

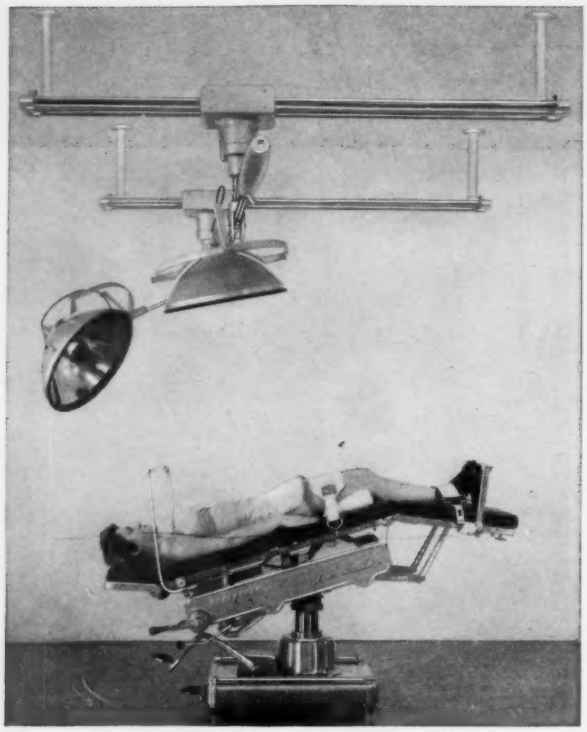
Heart Operation Removes Myocardial Aneurysm

What may be the first successful operation for removal of a myocardial aneurysm has been reported by William Likoff, M.D. and Charles P. Bailey, M.D., Philadelphia.

Although long survival with myocardial aneurysm is possible, it is extremely unlikely, the doctors said. However, life-prolonging surgery may now be possible for this type of aneurysm.

Such a defect was successfully removed from a 56-year old man at Hahnemann Hospital, Philadelphia. The operation, reported in the *Journal of the American Medical Association*, involved the removal of the sac from the left ventricle of the heart.

The patient recovered with little difficulty. After several weeks, he was able to walk and climb stairs without shortness of breath, or fast heartbeat —which he had before surgery.



Suprapubic Approach

An INNOVATION in Surgical Lighting

AMERICAN DUAL VIDEO LIGHT

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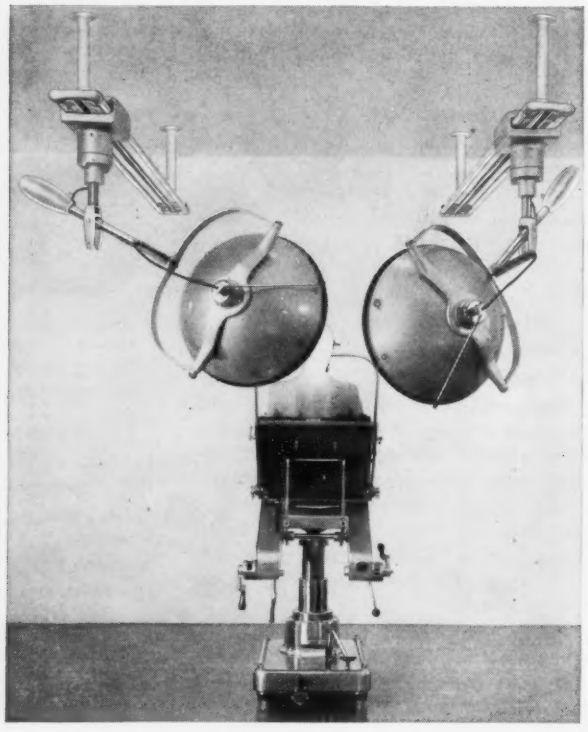
As will be seen, no floor lamp is necessary . . . each ceiling-suspended light head delivers intensity of from 1000 to 6000 foot-candles (12,000 in all) as desired by the surgeon.



Neurosurgery

Sterilizable handles are attachable at center of each lightbeam . . . it is now the practical prerogative of the surgeon to position the lightbeam exactly where he wants it. Circulating nurse may also maneuver light by the remote control.

Write Department HE-8

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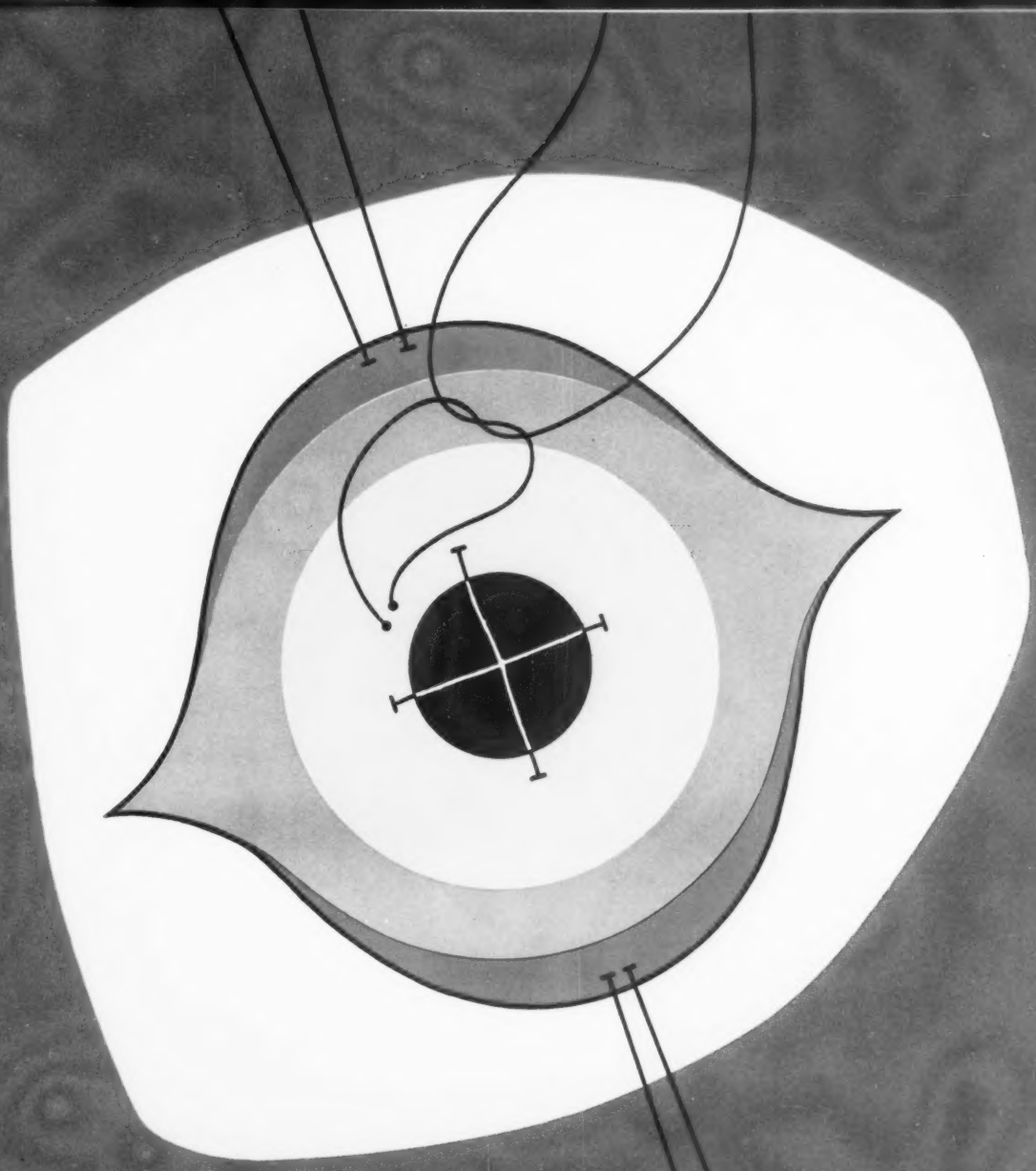

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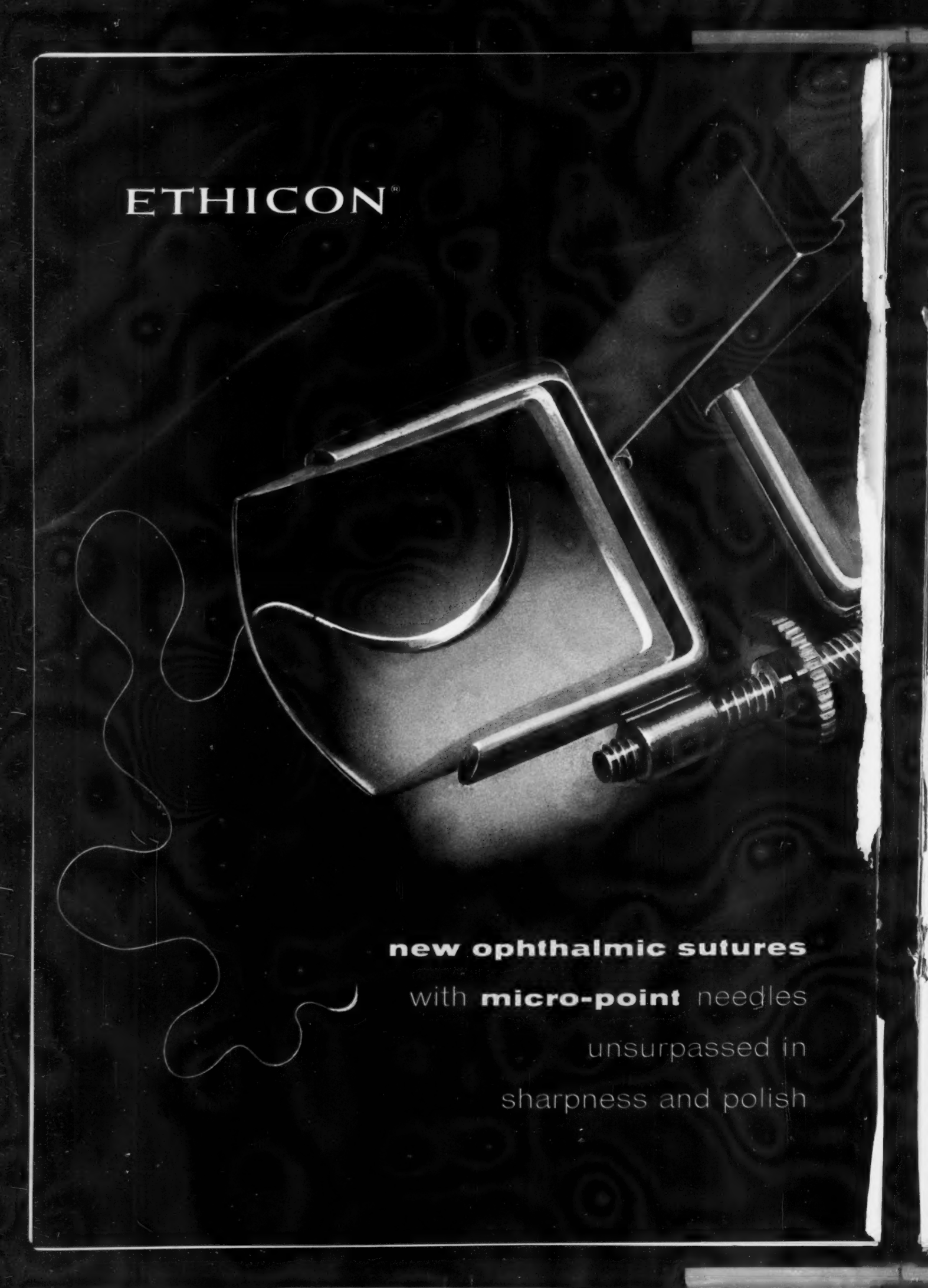

new ophthalmic sutures

with **micro-point** needles

unsurpassed in

sharpness and polish

News Briefs at Press Time

FOUNDATION GIVES CORNELL $750,000 FOR HOSPITAL ADMINISTRATION INSTITUTE

A $750,000 grant has been given to Cornell University by the Alfred P. Sloan Foundation to establish an institute of hospital administration.

Program, which will lead to degree of master of public administration in hospital management or master of business administration in hospital management, will require two years of intensive study on university campus at Ithaca, N.Y., and a year of residency in an appropriate hospital.

Grant includes a generous provision for fellowships, and only about a dozen highly qualified applicants will be accepted annually.

When unit is in full operation, as much attention is scheduled to be given to research in hospital problems as to instruction program. Part of grant is earmarked for research personnel. It is planned to develop an extensive inservice program for administrators and hospital personnel.

Four principal areas will be covered in two-year course: (1) general administrative practice, including work in organization and human relations; (2) specific management practices, especially finance, statistics, accounting, and related disciplines; (3) various specialties related to health care, including some coverage of broad community patient-care needs and methods and objectives of various professional groups involved in hospital operation; and (4) the application of administrative knowledge and practice to the specialized hospital situation.

First students will be admitted for term beginning in September, 1956.

HOUSE COMMITTEE APPROVES D.O. COMMISSIONS IN MEDICAL CORPS

Doctors of osteopathy would be recognized for Medical Corps commissioning, in a bill which has been approved by a House committee.

In favoring passage of bill (HR 483), Defense Department said it would add some 4,000 osteopathic physicians to the doctor-draft pool and relieve considerably armed forces' shortage of medical men.

BROOKHAVEN, OAK RIDGE HOSPITALS PLANNED

An appropriations bill passed by the House includes $6,040,000 to build a new plant for Brookhaven Medical Center, Long Island, N.Y., including a 48-bed research hospital, and $2.9 million for replacement of Oak Ridge (Tenn.) Community Hospital.

Existing facilities were described as firetraps.

SENATE COMMITTEE VOTES FOR CONSTRUCTION AND MENTAL ILLNESS SURVEY BILLS

Senate labor and public welfare committee has approved S. 849, providing for three-year, $90 million federal grants program to assist professional schools, hospitals, and clinics in construction and equipment of medical research facilities, and HJ Res. 256, calling for nationwide study of problems of mental illness.

BRIEFEST BRIEFS

Atomic Energy Commission will contribute $75,000 toward construction of first atomic energy reactor specifically designed for medical treatment and research, at UCLA Medical Center in Los Angeles...Appointment of Marion B. Folsom to succeed Secretary of HEW Oveta Culp Hobby came as no surprise. Folsom is first expert and first nonpolitical appointee to direct health, education, and social security activities since FSA and its successor, HEW, were set up...New director of National Institutes of Health is James A. Shannon, M.D., formerly associate director of NIH in charge of intramural research.

CIVIL DEFENSE GETS AHA EMPHASIS

With interest in adequate hospital defense planning admittedly not as high as it should be in many parts of the country, AHA apparently is attempting to build it up by scheduling a number of sessions on the subject for its convention this fall.

For report on one hospital's H-bomb preparations, see page 22.

Gordon H. Marshall

Calendar of Meetings

SEPTEMBER

6-16 Chicago Institute for Hospital Administrators, International House, University of Chicago

12-15 International College of Surgeons Convention Hall, Philadelphia, Pa.

12-16 Chicago Advanced Institute for Hospital Administrators, Chicago

17-19 American College of Hospital Administrators, Traymore Hotel, Atlantic City

19-22 American Hospital Association Traymore Hotel, Atlantic City

19-22 American Association of Nurse Anesthetists, Ritz-Carlton Hotel, Atlantic City

OCTOBER

1- 6 American Academy of Pediatrics Palmer House, Chicago

3- 7 American Association of Medical Record Librarians LaSalle Hotel, Chicago

5- 7 Montana Hospital Association Sidney, Montana

6- 7 Mississippi Hospital Association Hotel Buena Vista, Biloxi

11-12 South Dakota Hospital Association Yankton, S. Dak.

12-13 Indiana Hospital Association Student Union Building, Indianapolis

13-14 Nebraska Hospital Association Cornhusker Hotel, Lincoln, Neb.

17-18 Oregon Association of Hospitals Bend, Oregon

18-21 American Dietetic Association Auditorium, St. Louis, Mo.

19-20 Washington Hospital Association Davenport Hotel, Spokane

20-21 Operating Problems for Small Hospitals Institute, Hilton Hotel, Albuquerque

26-28 California Hospital Association San Diego Hotel, San Diego

29-30 American College of Osteopathic Hospital Administrators Annual Meeting, Statler Hotel, Washington, D.C.

30-Nov. 2 American Osteopathic Hospital Association, Hotel Statler, Washington, D. C.

30-Nov. 4 American College of Surgeons Conrad Hilton Hotel, Chicago

NOVEMBER

7- 9 Maryland-District of Columbia-Delaware Hospital Association, Shoreham Hotel, Washington, D.C.

7- 9 Association of Military Surgeons of the U. S., Hotel Statler, Washington, D. C.

7-11 Institute on Dietary Department Administration, Benjamin Franklin Hotel, Seattle, Washington

14-18 American Public Health Association Municipal Auditorium, Kansas City

14-18 Accounting & Business Practices for Small Community Hospitals Benjamin Franklin Hotel, Seattle

16-18 American Association of Blood Banks Palmer House, Chicago

17-19 Arizona Hospital Association Santa Rita Hotel, Tucson, Ariz.

19-21 American Surgical Trade Association Semi-Annual Meeting and Technical Exhibit, Conrad Hilton Hotel, Chicago

21-22 OR-CSR Institute, Battenfeld Auditorium University of Kansas Medical Center, Kansas City, Kan.

29-Dec. 2 AMA Clinical Session Boston, Mass.

DECEMBER

5- 8 American College Hospital Administrators 11th Fellows' Seminar, Evanston, Ill.

Folding Wheel Stretcher

Store three stretchers where you now store only one!

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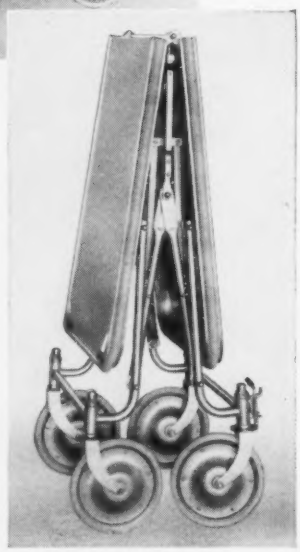

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State-Wide Volunteer Organization Aids Seattle Children's Hospital

By Janet W. Brady
Director of Public Relations
Children's Orthopedic Hospital
Seattle, Wash.

Above: Volunteer workers are the foundation of every phase of The Children's Orthopedic Hospital's service to sick and crippled children. Here a Red Cross volunteer helps a young patient with a project in the hospital's Occupational Therapy workshop. This therapy not only teaches the patient arts and crafts skills but also helps in exercising weakened muscles.

MORE than 15,000 women donate their time and services to what has been called the greatest hospital volunteer organization of its kind in the country—that of The Children's Orthopedic Hospital, Seattle, Wash.

Most hospitals are supported by local volunteer groups, but the organization at this hospital is state-wide. A total of 15,693 women belong to 478 guilds and auxiliaries throughout Washington. It is impossible to estimate the amount of time spent in behalf of the hospital through its volunteer workers, but just within the hospital itself last year, over 500 volunteers per month gave 52,160 hours of valuable assistance—the equivalent of 25 persons working 40 hours per week for one solid year!

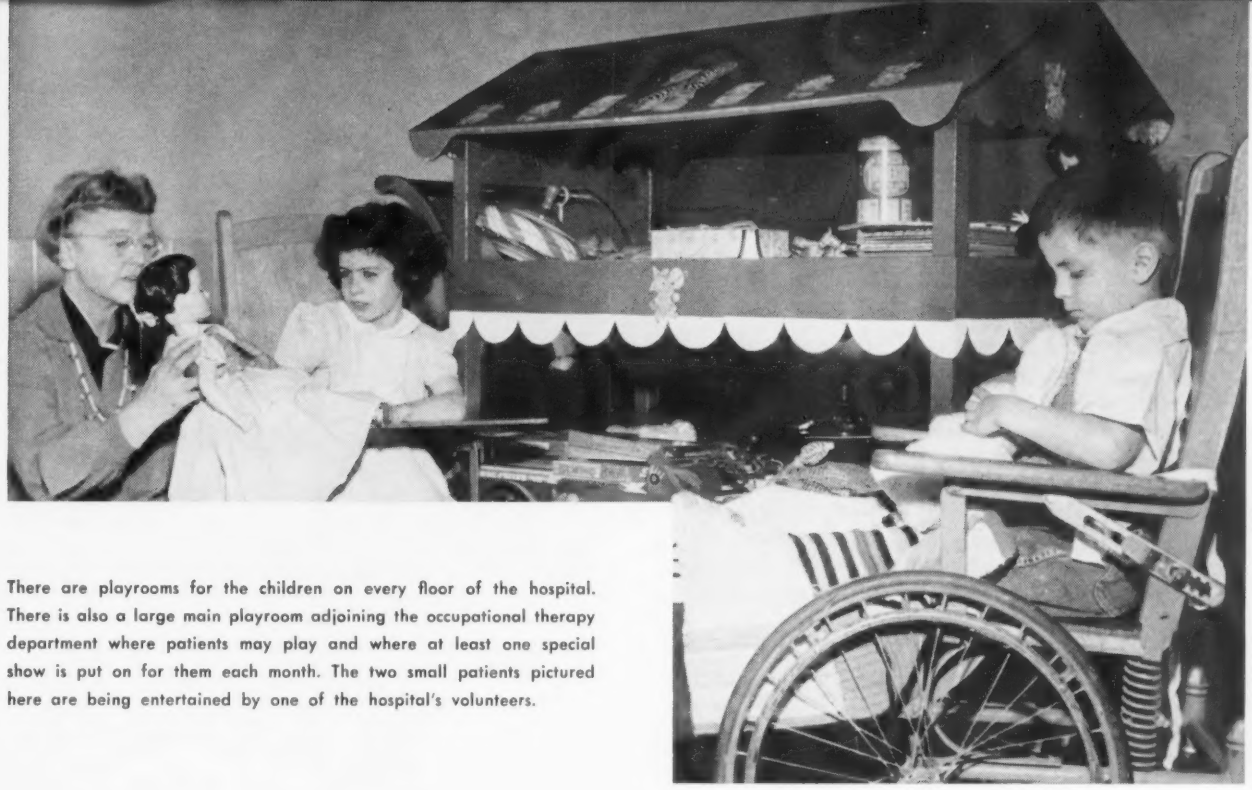
Volunteers are found in every phase of the hospital's service and life. Not all of them are members of guilds or auxiliaries. Many are just women interested in the hospital.

Women volunteers not only serve the hospital through guilds and auxiliaries, but also comprise the board of trustees. Since its founding, the hospital's management has been vested in a volunteer board of women trustees. It is a working board—not a pink tea party board. There are now 30 members, each one of whom gives many hours a week to hospital business. A volunteer advisory board of financial, business, and professional men counsels on finances.

Guilds were organized soon after 24 women established a seven-bed ward for crippled children in a Seattle hospital, on January 7, 1907, and have always played a vital role in the hospital's functioning.

The Children's Orthopedic Hospital was founded "to establish and maintain a hospital for the care and treatment of children. To make useful members of society out of those afflicted or deformed from birth or as the result of accident or disease, without prejudice of race, creed, or color." Since its founding, the hospital has cared for over 80,000 children who have come from all counties in Washington, other states, Canada, Alaska, South America, and the Philippine Islands.

In 1912, a 145-bed hospital was opened. The demands on the hospital's facilities became greater as the years passed.



There are playrooms for the children on every floor of the hospital. There is also a large main playroom adjoining the occupational therapy department where patients may play and where at least one special show is put on for them each month. The two small patients pictured here are being entertained by one of the hospital's volunteers.

The hospital, no longer strictly an "orthopedic" hospital, was becoming internationally known as a children's general hospital. The board of trustees decided to build a new structure that could adequately meet present problems and could be expanded to meet future ones. The 200-bed Children's Orthopedic Hospital, through the faith and active support of the people of the Northwest, became a reality in April, 1953.

Children from birth to 14 years of age are admitted regardless of parents' ability to pay. In 1954, 64 percent of care given was free. The total number of patients treated in the hospital since April, 1953, is close to 10,000.

Guilds and auxiliaries help the hospital through their many fund-raising activities and volunteer service, both in the hospital and in hospital projects, and by the tremendous amount of sewing they do for the hospital and the children. The generous spirit of unselfish giving is the force that makes the hospital a living ideal and inspires its constant growth.

Any group of women interested in the Children's Orthopedic Hospital may form a guild or auxiliary to assist in its support. Guild members each pay $5 yearly membership dues directly to the hospital. An auxiliary pays a $20 yearly membership fee for the entire group, regardless of the number of members. Meetings are usually held on the third Friday of each month, which has become known as "Orthopedic Friday."

A clearing house for hospital guild and auxiliary news is the business-like monthly "round table" meeting, where presidents and other members of Orthopedic groups meet from 10:30 a.m. to 12 noon sharp to get pertinent information about the hospital through reports given by board members. This information, with a monthly bulletin, they take to their Orthopedic group meetings.

Hundreds of projects are planned and executed every year by guilds and auxiliaries to raise money for the maintenance of the hospital. Three major projects are held annually with many or all Orthopedic groups working together to make them top money-raisers. They are the Penny Drive, the Friendly Exchange Sale, and the Garden Sale. In 1953 the Orthopedic groups raised $392,551.30.

"Open Your Heart—Help Sick and Crippled Children" is the theme for the annual Penny Drive, which is in its 24th year. This is the major fund-raising drive for the hospital, with all guilds and auxiliaries taking part. It is handled entirely by volunteers and is state-wide—wherever there is an Orthopedic organization. Heart-stamped envelopes are delivered in a very organized and systematic way to homes and offices and, at the end of two weeks, are picked up. The Penny Drive gives persons from all walks of life the chance to help support the fine work that "their" hospital does. Last year it netted $124,400 for the hospital.

The annual Friendly Exchange Sale and Garden Sale require hundreds of Orthopedic volunteers to put them across. The Friendly Exchange Sale, a three-day event, is a glorified rummage sale held in a downtown location. Articles are donated, and profits go to the hospital. Last year it netted $17,000. The Garden Sale, in April, turns over its proceeds to maintain the hospital's grounds and gardens.

The tremendous amount of time and energy given by Orthopedic volunteers is of incalculable help to the hospital. The number of hours given reaches an impressive total, but more important is the fact that they are given consistently.

The hospital maintains three stores in Seattle shopping districts which are staffed by Orthopedic volunteers and operate five to seven days a week. The Orthopedic Project Shop features projects made or sponsored by the hospital's guilds and auxiliaries. An added attraction is the "little gallery" with paintings for sale by famous Northwest artists. One woman volunteers her time to staff the Project Shop every day. During the busy months of November and December two to four volunteers assist in the Project Shop.

(Continued on next page)

The Orthopedic Corner Cupboard, staffed daily by five women volunteers, offers distinctive gift items for sale. As an added convenience for the busy shopper, luncheon is served daily, with volunteers acting as waitresses.

Staffed daily by three women volunteers, the Orthopedic Thrift Shop offers a vast stock of secondhand items donated by Orthopedic members and friends. Among the "finds," besides clothing, are many collectors' editions in books and rare prints, as well as bric-a-brac.

Within the hospital, five to 10 volunteers daily staff the Orthopedic "Hospitality Center," where fountain lunch service is available and a variety of gifts and magazines are for sale. In the hospital's work center, almost all the sewing for the hospital is done by volunteers. Countless children's garments and special supplies are made here.

Throughout the hospital, the volunteers' uniforms are evident—in the offices, where they type and file; in the wards, where they feed and read to the children; and in the clinics, where they assist in many ways. Their work is varied and important. Without it, the hospital could never carry out its purpose.

Junior Orthopedic Guilds (JOGs) are patterned after the senior guilds and carry on many activities and money-making projects. They help support the manual training shop at the hospital and supply funds with which to buy new materials for the work done by the small patients in the occupational therapy shop. There are over 2,050 boys and girls in the junior association—over 71 guilds—paying dues of $1 a year, and giving regular hours to the hospital as volunteers. They supply holiday favors, provide entertainment, help in the playrooms and outdoor play areas, help feed the children, and serve in many other needed ways.

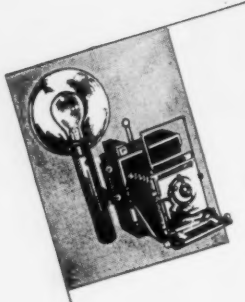
The Children's Orthopedic Guilds (COGs) are groups for seventh, eighth, and ninth graders, whose purpose is to raise funds for and give service to the hospital. Membership is open to any boy or girl 12 to 15 years of age. It is felt that COG groups will fulfill a need for service in the lives of junior high school students and act as a preparation and springboard for fuller activity when the guild members reach senior high school and are eligible for membership in the Junior Orthopedic Guilds (JOGs).

Below: Christmas time is not lonely or sad at The Children's Orthopedic Hospital. Each child has written a letter to Santa Claus and has hung his stocking beside his bed. Santa arrives Christmas morning with a heavy load of presents for all the little patients and greets each child individually. Behind this scene lie weeks of planning and making ready. One phase of the preparations is the wrapping and labeling of gifts, done here by two members of the hospital's Junior Orthopedic Association. The girls are members of a JOG (Junior Orthopedic Guild) for high school boys and girls. There are over 2,050 boys and girls in more than 71 guilds.

Left: The attractive hospitality center at the hospital is open seven days a week and is staffed by guild volunteers. Fountain service, magazines, gifts, toys and notions are all found here.

Right: Almost all the sewing for the hospital is done in the Work Center by women volunteers. Mrs. Dorothy Shave, director, gives a volunteer instructions on the sewing of a dress for a little girl patient. Special supplies, as well as children's garments, are made here. In 1954, volunteers served a total of 18,321½ hours in the center, making 20,684 articles.

Right: If the child cannot be moved from his room Occupational Therapy volunteers come to his bedside. Here a volunteer supervises a small patient as he makes clay models. Other OT projects hang above his bed.



Hospital Topics ..... Goes Calling

. . . on T. Gordon Young

Director

Hospital for Special Surgery

New York City

Exterior of the building, which is on East 70th St. at the East River Dr.

Above, right: Mrs. Edward McCabe, director of volunteers (r.), goes over assignment schedule with Mrs. Celia Light in volunteers' lounge —decorated in up-to-date color scheme of charcoal and pink. Mrs. McCabe has separate office adjacent to lounge.

Distinction of establishing one of first bone banks in country is claimed by the hospital. Below: Hazel Evans, operating room supervisor, is shown removing a jar of bone from the bank, which is situated in a separate small room in the operating room suite. Bone is kept in ordinary Mason jars which are covered with rubber dam and stored in Frigidaire food freezer which is maintained at —20° F.

Bright colors, sunny rooms, and a riverside location help make the new Hospital for Special Surgery about as cheerful-looking as any hospital can be.

Each patient floor has a solarium overlooking the East river, so that patients may get the maximum benefit of the view of the nearby bridge and the skyline.

T. Gordon Young

On the pediatric floor the solarium is a playroom decorated with wall paper featuring toy soldiers and cartoon characters.

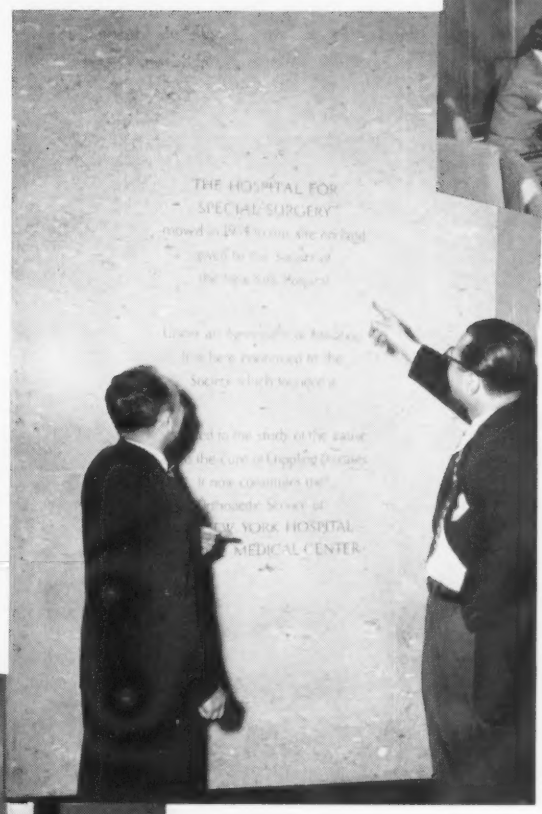
The new building is situated across the street from New York Hospital, for which it provides the orthopedic service.

When the structure was opened May 25, 72 patients were transferred in three hours, with a minimum of disturbance in schedule.

The 170-bed hospital has many special clinics, some of which are for cerebral palsy, scoliosis, club foot, arthritis, polio, and multiple sclerosis.

Large, well-equipped physical therapy and occupational therapy departments play a major role in the rehabilitation of patients. The physical therapy department has a big indoor pool into which patients are lowered by a hydraulic lift—similar to that used at the post-polio center at Rancho

Above: Small printing press had just been purchased by hospital for use in occupational therapy department. Doris Nichols, director of the department, watches Seth Colodney, a post-polio patient, as he sets type. Setting type is considered good for aiding thumb motion, while operation of the press helps improve function of shoulder muscles. Some hospital forms may be run off on press.



Above, right: Holding a meeting in the beautifully paneled board room were (l. to r.): Pamela Mitchell, employed in fund-raising; Mrs. Walter D. Fletcher, vice-president of the board; Philip D. Wilson, M.D., former hospital chief of staff, and Samuel S. Duryee, president of the board.

Above, center: Norman Bolotin (l), assistant director, and Harold Tillman, night accountant, point out legend on wall of lobby which describes hospital's purpose—study of the cause and finding of a cure for crippling diseases.

los Amigos, Hondo, Calif. (See HOSPITAL TOPICS, September, 1954). During the polio season there are usually about 75 post-polio cases in the hospital. There were 15 in mid-June.

Total number of operations in the four operating rooms is only six or seven a day, on the average—but each operation may last for several hours, because the cases are almost entirely orthopedic.

The hospital was organized in May, 1863, by the New York Society for the Relief of the Ruptured and Crippled and was known until 1940 as the Hospital for the Ruptured and Crippled. In that year its name was changed to The Hospital for Special Surgery.

(Continued on next page)

Jeanne Hicks, staff physical therapist, with Evelyn del Valle and Dwight Reid in playroom on pediatric floor. Dwight gets around floor very well on his bed-cart. Usually about one-third of hospital's patients are children.

Above, left: Mrs. Maureen Gettens, operating room technician, showing location of x-ray controls right outside the operating room—convenient, yet safe from explosion hazards. Also conveniently situated is the central sterile supply room—right next door to the operating room. Above, right: Visiting physicians or students may observe surgery from glassed-in balcony between two operating room suites. Edith Dee Hall, R.N. (l.), New York City, secretary, National Conference Planning Committee, Association of Operating Room Nurses, observes operating room team in action as Miss Evans speaks to them on two-way intercom system.

Below: Ruth Revzen, occupational therapist, and Euna Strauss, speech therapist, with occupational therapy unit built to hospital specification. Miss Revzen shows how board on which patient stands can be adjusted to individual's height. Table does double duty—gives patients the advantage of social contacts with one another at the same time they are working at the table.

Air-conditioning in the surgical suite is controlled by Miss Evans from her office, with buttons shown here.

Effective Interdepartmental Communication in the Hospital*

By Edna E. Peterson, R.N.
Director, School of Nursing and Nursing Service
Jewish Hospital, St. Louis

THE subject, interdepartmental communication, immediately focuses our attention upon a recoginition of principles involved in the development of good attitudes in human beings. In achieving this goal there is no short cut. It is accompanied only by long, careful, understanding efforts.

Attitudes cannot be changed unless the persons concerned want them changed. If we hope to develop good attitudes in the personnel, we must make them realize that we in charge are willing to listen with understanding. We must have rather good answers for the questions they raise. What has this concept to do with communications? Everything. On it the whole aim—constructive action—is based.

All too frequently, we find ourselves criticizing our coworkers because they do not carry out policies, do not relay them to a subordinate group, or do not get information back to those to whom it should go. The source of the difficulty may frequently be found, not in the ineffectiveness of the department heads, but rather in the poor system of communication within the organization in which they are functioning.

We in the hospital field have been slow to accept the idea that interdepartmental unity of purpose can best be accomplished through understanding, not orders; through motivation, not subordination. The complex organization and function of today's hospital has literally forced us to recognize the principles of management that have been employed for a long time by industry.

True, the management function in a hospital is a difficult one. Informed industrial leaders and other students of management know that the higher the percentage of production depending on the efforts of people as contrasted with machines, the more difficult management becomes. In the hospital we are dependent almost 100 percent on human beings. Too much cannot be said about the need to explore the human relationships in the organizational structure of the hospital. We are faced with the importance of understanding hospital personnel in a changing economic, technological, and sociological environment.

The hospital executive cannot today set himself apart and smugly say: "I'm dealing with matters of life and death, and I don't have time to consider all these personal factors. I give the orders!"

The wise executive does not seek his power expression through his status and prestige in a post of authority. To antagonize and to influence at the same time is impossible.

Ordway Tead offers this definition of democratic leadership: "Democratic administration is that direction and oversight of an organization which assures that aims are shared in the making; that working policies and methods are agreed upon by those involved; that all who participate feel both free and eager to contribute their best creative effort; that stimulating personal leadership is assured, and that in consequence the total outcome maximizes the aims of the organization while it also contributes to the glowing selfhood of all involved in terms of clearly realized benefits."*

Effective communication in the hospital originates with the executive in charge. Cooperative accomplishment is the result of administrative permissiveness. The executive

(Continued on next page)

*Presented at the Second Annual Conference, Association of Operating Room Nurses, St. Louis, January 24-27, 1955.

*Tead, Ordway—*The Art of Administration*, p. 134; New York: McGraw Hill Book Co.

must be a living demonstration of desire to achieve unity through this willingness to create an atmosphere in which the department heads will feel confident.

Stress must be placed not so much upon departmentalization as upon the unity of the departments.

The base of all effective communication programs is the top executive. I use the term executive here to denote the highest level in each organization unit. The principle carries on to each unit level—the administrative assistant; the department head, and each individual employee.

Let us not be hasty in assuming that faulty communication is the result of lack of ability on the part of the head to present, interpret, and discuss with his own groups the policies that may be proposed or changed.

The underlying aim of communication is a meeting of minds on a common issue. Surely the communication is more than imparting or securing information. It is an interchange among persons who seem to find it worthwhile to get together and talk things over.

One of the first essentials is an organizational chart. However, to stop here would be ineffectual. The situation is analogous to that of a sprinkler system for fire protection. The central main supplies water to dozens or hundreds of tributary mains. But this is a one-way operation.

The executive may, as a central main, have a structural organization which gives out communications. But it's just as important that the communications return to him. The current trend of hospitals to develop the conference technic through in-service programs has done much to bring about this two-way communication.

Granted that the organizational chart is completed and that the departments are listed in perfect order, do the department heads know what the channels of communication between departments are? Do they use the channels? Suppose they have been cleared and understood by all concerned, they are useless, unless information is passed up and down and horizontally to all levels.

Frequently we forget some of the levels of personnel. It is often lack of communication that leads to individual and group insecurity. This insecurity in turn develops individual and group resistance to changes that are inevitable in a field as dynamic as the hospital.

Effective communications comes more quickly when we have good interpersonal relationships. The charts are useless unless they are accompanied by job analysis which includes the general plan of operation and the service of the hospital.

One of the important factors in setting up lines of communications is a thorough review of the principles upon which the entire organization is based. Whether one is thinking in terms of communication from the top executive to the department head, or from the department head to the worker within the department, or from one department head to another, the principles of organization remain always the same.

First, every necessary function involved in the objectives of the organization is assigned to one unit of that organization.

Second, the organization should never grow so elaborate as to hinder work accomplishments.

Third, the responsibilities assigned to the unit must be clear-cut and understood. No function is assigned to more than one independent unit. Overlapping causes confusion and delay.

Consistent methods of organizational structure should be applied at each level of the organization. This is very important, and a MUST in order to achieve cooperation for interdepartmental plans.

Every member of the organization from the top to the bottom knows to whom he reports and who reports to him. No member reports to more than one person. Responsibility for a function must be matched by the authority to perform that function.

Independent individuals or units reporting directly to an immediate supervisor should not be more than can be effectively co-ordinated and directed. Channels of command must not be violated by the various units. Authority and responsibility for the actual performance of the work should be decentralized as far as possible, to the department head and to his unit, as long as decentralization does not hamper necessary control over policy matters. An effective plan for hospital control always includes a detailed plan for communication. This planning cannot be completed by one person. Every person who shares in the work must share in the planning.

What is the result to be attained? How is it to be done? Who will do it? Effectiveness is attained when all concerned are parties to making decisions. Participation gives a sense of importance. It's not a new concept, but rather the application of the educational principles that participation is essential to learning, accepting, and following through.

In summary, organizational charts must be available. Job descriptions and performance standards must be known by the individual workers. Delegation of authority to subordinates is a MUST. Be sure the individual concerned understands what his authority is. Encourage a free exchange of ideas and criticisms, always respecting opposing views or opinions.

Include all workers in your plan for communication. This keeps all adequately informed of the activities within the hospital. It plays a major role in getting department heads to take an over-all view of problems rather than considering all hospital activity in the light of the manner in which it affects their department.

Thinking should be hospital-wise, not department-wise. Speak the language of those with whom you communicate, so that your communication is clearly understood and not merely a directive. There is no place for sarcasm in written or spoken communication.

How can we best assure effective communication by department heads back within the groups which they represent? First, the executive must plan for the necessary group structures and for face-to-face meetings for the channeling of decisions and reports.

Secondly, the department head must have the necessary leadership, so that back among his own group he can be as effective in presentation, interpretation, and persuasion. Good will and good ideas, coupled with knowledge and good procedures, are essential.

Communication dealings with new policy questions must frequently be broken down into a personal, face-to-face procedure. There is no substitute for face-to-face conferences in the communication of important ideas.

Perhaps one reason that the simple truth, "The way to confer is to confer," has not been freely used is that those who are in charge fear loss of prestige.

Additional methods used to establish communication are regular conferences with various groups, printed material, sound films, and an organized program of instruction for all units, a program which must be kept active and up-to-date.

Effective communication is the result of planned concern for every individual in the organization, and the end result is a team spirit.

Pictured at the Massachusetts Hospital Association dinner in the Hotel Statler are (left) newly-elected president Guy W. Brugler, M.D., and Mrs. Brugler and (right) guest speaker C. Sidney Burwell, M.D., LL.D., S.D. (hon.), formerly Dean, Faculty of Medicine, Harvard University, and Mrs. Burwell. Delegates chose May 10th as the date for next year's meeting.

M.H.A. Holds 19th Annual Meeting

● Guy W. Brugler, M.D., administrator of Boston's Children's Medical Center, was named president of the Massachusetts Hospital Association at the recent 19th annual meeting held at the Hotel Statler, Boston.

Other officers named were Dan Traner, administrator, Lynn Hospital, president-elect, and Miss Georgie M. Boulter, administrator, Boston New England Baptist Hospital, treasurer.

Wesley D. Sprague, administrator, Brockton Hospital, and Harlan L. Paine, Jr., administrator, Winchester Hospital, were named trustees of the association for four year periods. Also named to the board of trustees to fill the unexpired term of the late Dr. Myrtle B. Crudim, was Miss Marjorie H. McComb, R.N., administrator, Leominster Hospital.

More than 500 representatives attended the one-day meeting. Included in the morning sessions were discussions on hospital accounting systems, public education, Blue Cross, the hospital reimbursement law and meetings on auxiliary activities which involve approximately 47,000 volunteers in hospitals throughout the state.

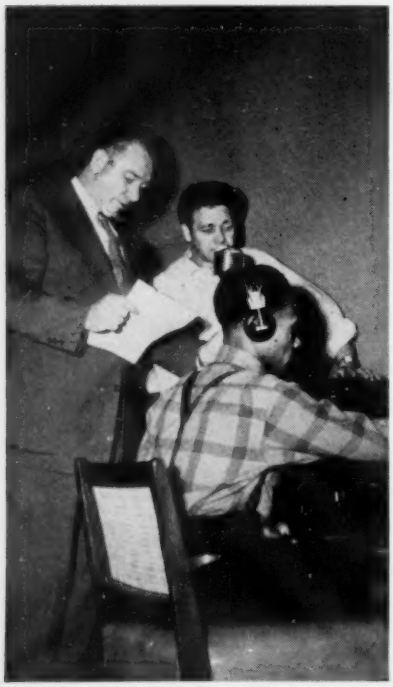
The afternoon session included a forum on new service demands for hospitals and a discussion of hospital costs as seen by hospital trustees. E. Benjamin Redfield, president and trustee of Lynn Hospital, said: "To compare today's hospital expenses with those of relatively recent years is not practical, for today's costs include so many new procedures and supplies, so much new equipment and so many specially trained workers that no comparison is possible." Mr. Redfield called modern hospital care and treatment "a truly exceptional bargain." He predicted that hospital costs may continue to show an upward trend if the overall national economic picture continues upward.

Other members of the panel were C. Wallace Cederberg, president, Sturdy Memorial Hospital, Attleboro; the Rt. Rev. Msgr. A. C. Dalton, LL.D., Director of Catholic hospitals, Archdiocese of Boston; Alexander J. Guffanti, trustee, Wesson Memorial Hospital, Springfield; and Dr. Charles F. Wilinsky, trustee, Beth Israel Hospital, Boston, and past president of the American Hospital Association.

VA Hospital Holds H-Bomb Drill

By Frances Henkin

Above: Nurses and orderlies carry the litter patients to the elevators for evacuation to the basement. The patients' bed blankets are used as stretchers. The sides of the blankets are rolled tightly so that a firm grip is possible. Below: Ray Q. Bumgarner, assistant manager and coordinator of the drill, uses a short-wave radio set up in the command post to communicate with the rest of the city after the bombing attack.



When 60 cities participated in a nationwide civil defense drill in June, the VA Research Hospital, Chicago, carried out a detailed disaster evacuation drill within the hospital.

As a result of the joint efforts of all key personnel, a "hospital in miniature" was planned for the basement area during the hypothetical H-bomb attack. All hospital personnel were thoroughly indoctrinated so that each person knew exactly what his job was to be.

At 11:07 a.m., when sirens sounded the "alert" signal, an emergency kitchen, surgery, and 40-bed ward were set up in the basement.

At 1:50 p.m., when the "take cover" siren sounded, the disaster evacuation drill began. Twenty ambulatory patients and 20 staff members acted as the patients to be evacuated from the fourteenth floor to the basement area. Ten men took the role of ambulatory patients, six were in wheel chairs, and the other 24 acted as litter cases.

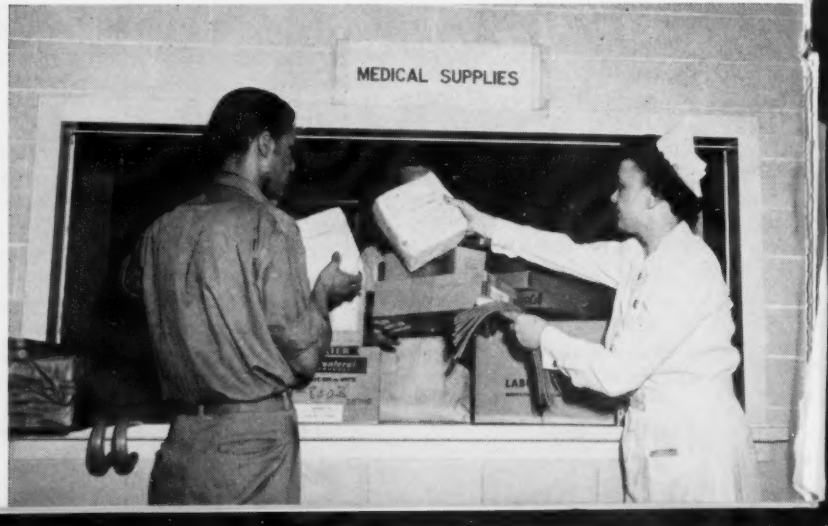
Nurses were posted at strategic points in the corridors to direct those being evacuated to the nearest elevators. The ambulatory and wheel chair patients came first, then the litter cases, who were carried from their rooms on blankets serving as stretchers. Three or four men carried each patient. Two elevators serving the fourteenth floor took the patients to the temporary ward in the shelter area.

As soon as the entire floor was evacuated, patients' charts, narcotics, and the files were assembled for removal to the safe temporary ward area. The total evacuation was completed in 15 minutes.

In the basement all department heads gathered at the coordinator's post to direct the underground hospital. Casualties were registered, medical and food supplies coordinated, and personnel were blood-typed and assigned specific duties. The typing was done to provide a "walking blood bank." As soon as an injured person's blood type was determined, the donor was paged and sent to the ward.

During the hypothetical bombing attack, it was assumed that all utilities were knocked out. In preparation for this,

Below: Mary Grivest, R.N., chief, nursing service, gets emergency medical supplies from a temporary supply room. The medical supplies are placed near the ward where casualties are cared for.



temporary lights operating on power from a gasoline-driven generator were strung up throughout the basement and first floor. It was planned to take drinking water from Lake Michigan which would be free of radioactivity 24 hours after the bomb was dropped.

From the coordinator's station emergency communications were set up. A sound-power phone, requiring no electricity, was connected to the command post on the first floor. The assistant manager of the hospital was in charge of the post—the nerve center of the entire operation. A short-wave radio was installed in this room to provide connection with the outside world.

As the patients and personnel reached the basement they were sent to a contamination room to be checked for radioactivity. If they were radioactive, they were sent to a decontamination room. If not, they were directed to the areas to which they had been assigned previously. Temporary signs were posted to identify each room and area.

Patients were taken to the emergency ward, where stretchers were set up to receive them. The nursing station here was set up next to the hospital's drug supply room.

An emergency kitchen was set up in the incinerator room. Some cooking heat was obtained by attaching flues from the incinerator to empty oil drums which served as stoves. Additional heat came from scraps of wood used to build fires under the drums. Simple foods such as hot dogs were prepared. Dry foods were available, but it was pointed out that hot meals were especially important in times of stress. Personnel were served, standing up, from wood planks set on barrels. All food and water was Geiger counted to make sure it was safe for consumption.

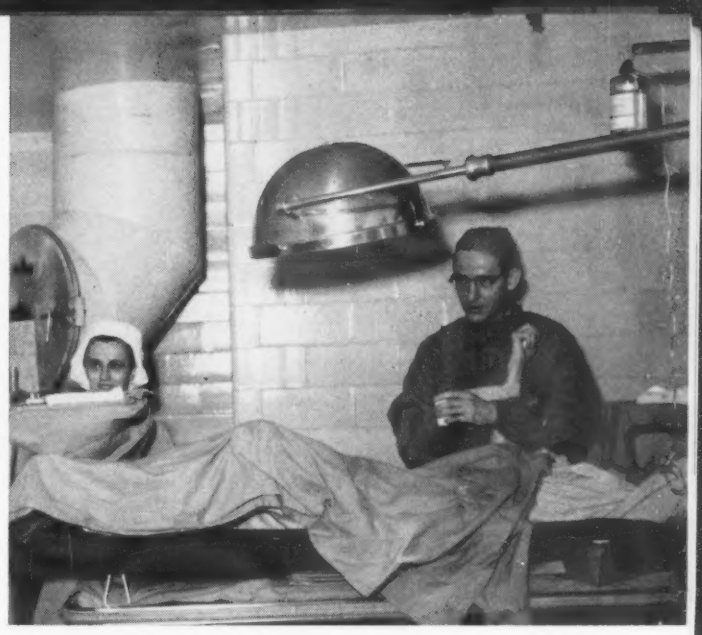
A temporary operating room with lights on batteries was equipped to handle all surgery requirements. This unit was placed near the temporary kitchen so that hot water would be available for instrument sterilization.

Another room was set up to care for people caught in the street in the vicinity of the hospital. Special containers were placed in this room for disposal of their radioactive clothing. Shower facilities were provided for them and they were then given sheets to wear.

A round-table discussion was held at the command post immediately following the drill.

Department heads agree that the drill was successful, that many situations had developed that would aid in the formulation of better future plans, and that further study was necessary to determine whether or not there would be adequate safe areas in the hospital for the evacuation of all patients and personnel.

Further recommendations were: improvement of interward messenger activities; identification of all key officials; a better method of registration and identification of patients and personnel; formation of a medical officers' pool from which doctors could be drawn and assigned as needed, and a study to determine the type and quantity of standby equipment and materials that should be stored in the safe areas.



Above: A completely equipped operating room is set up in what is ordinarily the hospital's soiled linen room. The lights are run on either batteries or a mobile generator.

Below: Every incoming person to the shelter area is checked with a Geiger counter for signs of radioactivity. If any radioactivity is found, they are sent to a decontamination room for treatment.

Below: Casualties of the H-bomb attack are treated for shock and injuries in the temporary basement ward. Orderlies carried lanterns to furnish additional light.

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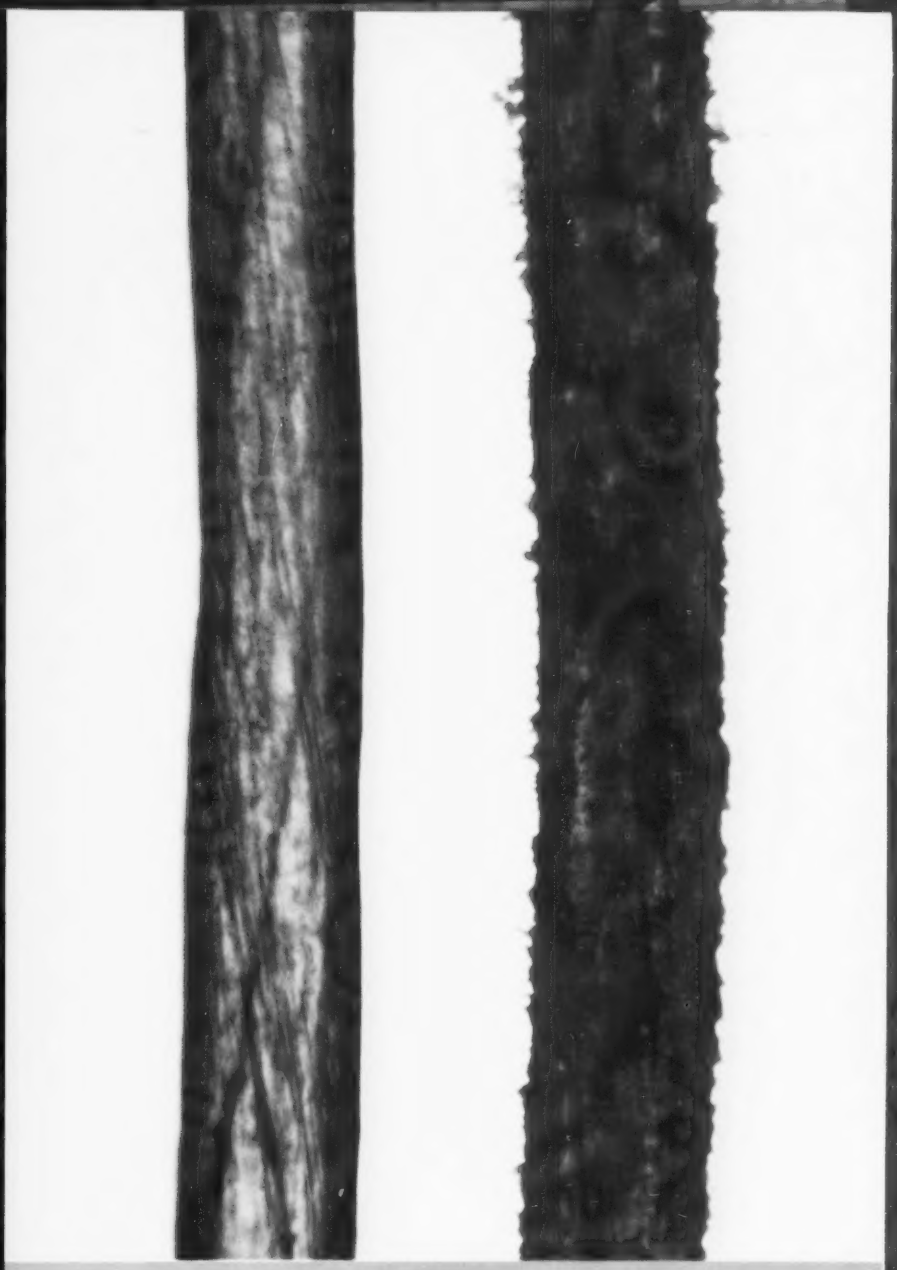
Research shows why D & G gut is stronger

PHOTOMICROGRAPHY SEES WHAT THE HAND CANNOT FEEL

Photomicrographs (unretouched) by E. J. Thomas, Stamford Laboratory of the Research Division of the American Cyanamid Company, Stamford, Conn.

Method used: dark field, transmitted bright field illumination, 138 x. Material used: medium chromic gut, size 5-0.



D & G gut

Photomicrograph shows the smooth surface of D & G SURGICAL GUT, with practically no fraying or roughness. *Reason:* Carefully controlled slitting of plies plus uniform twisting provides a smooth, well-bonded strand. No need to grind it to size. Gentle polishing gave the matte finish. *Result:* the full natural strength of each gut ribbon (ply) is preserved; the strand is not frayed by grinding.

Another leading gut

Photomicrograph reveals rough, frayed surface of another leading brand of gut. This has been ground to size. Gut processed in this way appears very uniform in diameter to the naked eye. But the photomicroscope reveals serious imperfections which may cause fraying and loss of strength when the knot is tied.

see exhibit on next page

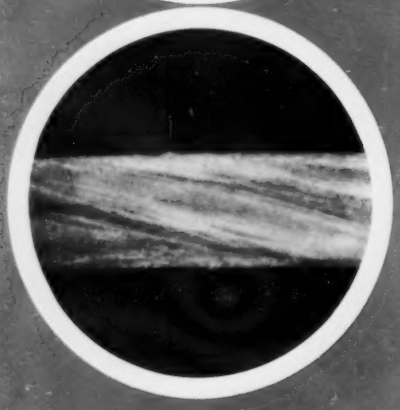
SUTURES AND OTHER D&G® SURGICAL SPECIALTIES

DAVIS & GECK INC.

A UNIT OF AMERICAN Cyanamid COMPANY

DANBURY, CONNECTICUT

Photomicrography shows why D & G gut is more flexible



D & G GUT

Firm, even cohesion of plies is apparent in this photomicrograph of a D & G SURGICAL GUT suture.
Reason: plies were twisted into a strand before suture was chromicized. Natural cohesive forces of moist untreated collagen firmly bond the plies together and hold the twist.
Result: under stress, plies of the suture hold together. The D & G gut is more flexible and knot strength is greater.

ANOTHER LEADING GUT

Photomicrograph detects separate and distinct plies in a strand of another leading brand of surgical gut. Here each ply was chromicized before they were twisted into suture strands. Such "ribbon chromicizing" hardens the surface of each ply, decreasing the natural bonding action, lowering the flexibility and tensile strength of the suture.

Photomicrographs (unretouched) by E. J. Thomas, Stamford Laboratory of the Research Division of the American Cyanamid Company, Stamford, Conn.

Method used: dark field, reflected illumination, focus on crest of surface, 38 x. Material used: medium chromic gut, size 00.

see exhibit on previous page

SUTURES AND OTHER D&G® SURGICAL SPECIALTIES

DAVIS & GECK INC

A UNIT OF AMERICAN Cyanamid COMPANY

DANBURY, CONNECTICUT

James Bennett, M.D., pathologist, used tissue samples to make graphic explanation of disease possibilities to telecast audience.

Seattle Hospital Televises Surgery to Public

● The first telecast of "live" surgery to the public in the Northwest area, made recently from The Doctors Hospital, Seattle, was a "hit" with the public and hospital officials.

Lung surgery from one of the hospital's operating rooms was the main feature (35 minutes) of an hour-long program called "Operation Tuberculosis," dealing with prevention and treatment of the disease.

Operations manager Tom Dargan of Seattle station KING-TV, who produced the show and provided the commentary, estimated the potential audience for the program, televised at 8:30 on a Friday evening, at 700,000.

Dozens of persons called the hospital to congratulate the staff on the program. Others commented favorably by letter or in person. A Seattle daily paper, which ordinarily almost ignores the competing medium of television, interviewed the surgical patient the Monday after the operation and published a story and photograph of his convalescence.

"For the last week before the telecast, I didn't do much but make plans for it," said hospital director Robert F. Brown, M.D. "It was a lot of work, but I'm convinced it was worth it. We haven't had any reaction that wasn't good! Television seems to be a very effective medium for a hospital to use in building good public relations."

More than two months of preparation, and the cooperation of the King County Medical Society, the Anti-Tuberculosis League of King County, and local and state health departments were required to put the program on the air.

Most of the burden of planning fell on the hospital staff, particularly Dr. Brown and Frank Fischer, director of plant operations.

One of Dr. Brown's duties was briefing TV personnel who worked on the program. Mr. Dargan and his co-producer, Bernard Carey, witnessed four similar operations at

(Continued on next page)

Patients, visitors, and friends of the hospital watched the surgery on sets in the lobby, solaria, and other areas. Patients were especially interested in the procedure—operation on the lung of a 29-year-old man. Surgery part of program lasted 35 minutes.

The hospital board room also served as a TV studio. Panel of five physicians who spoke from the board room as part of "Operation Tuberculosis" were (l. to r.): Norman Arcese, M.D.; Daniel W. Zahn, M.D.; John H. Fountain, M.D.; E. Harold Laws, M.D., and Byron F. Francis, M.D. Extra lights had to be set up in the room, and heavy draperies were hung for acoustical reasons.

SEATTLE HOSPITAL TV continued

the hospital before they brought in their cameras. Cameramen and sound crews watched one preliminary operation to be sure they would not faint or become squeamish during the telecast.

Problems for the hospital included providing adequate power supplies for the transmitting equipment, stringing hundreds of feet of cable without blocking halls or stairs, and locating the various program "scenes" where they would not interfere with hospital operations.

A last-minute problem was electron radiation which was interfering with transmission. The source of interference was found quickly in a roof-top air-conditioning unit, and eliminated.

Why Administrators Leave Indiana Hospitals

● The reasons for hospital administrators changing positions and the percentage of turnover in hospitals of various sizes were studied in a statistical survey undertaken recently by the Indiana Board of Health. The results were revealed in a recent issue of "Hoosier Hospital Harmony," published by the Indiana Hospital Association.

This subject is only one considered in a comprehensive study of Indiana hospitals, according to J. B. H. Martin, the board's special consultant in hospital administration. Complete, official results will not be available for some time.

The survey shows that the six main reasons why administrators leave Indiana hospitals are: retirement; transfer to a larger hospital with increased opportunities; established policies of tenure in some church hospitals; personal reasons not related to hospitals; lack of mutual agreement in understanding between the governing board and the administrator as to his duties and responsibilities; and inability of some administrators to meet the responsibilities of the position.

A breakdown showing the percentage of turnover follows:

Number of Beds	A	B	C	D	E	F
0 to 24	20	14	3	2	1	30%
25 to 49	28	7	8	8	5	75%
50 to 99	35	14	7	5	9	60%
100 to 149	15	4	10	1	0	73%
150 to 199	7	2	4	1	0	71%
200 to 249	11	3	2	6	0	73%
250 to 399	10	1	8	0	1	90%
400 and over	3	0	3	0	0	100%*

Legend

A—Number of hospitals in the group.

B—Hospitals which had no changes of administrator.

C—Hospitals which had one change of administrator.

D—Hospitals which had two changes.

E—Hospitals which had from three to seven changes.

F—Percent of hospitals in the group which had changes in administrators.

*All of these changes were due to the retirement of the administrators.

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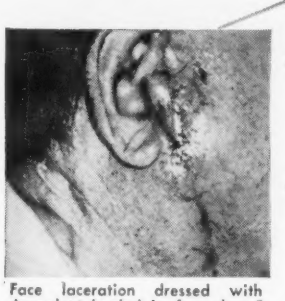
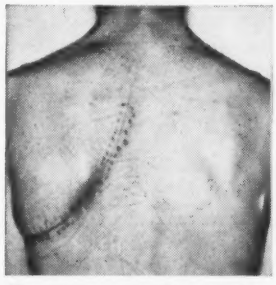


Face laceration dressed with Aeroplast healed in four days.[2]

Bilateral inguinal hernia incisions protected by Aeroplast 4th post-operative day.[1]



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1. Rigler, S. P. and Adams, W. E.: Experience with a new sprayable plastic as a dressing for operative wounds, Surg. 36:792 (Oct.) 1954. (University of Chicago Clinics, Chicago, Surgical Service).

2. Choy, D. S. J.: Clinical trials of a new plastic dressing for burns and surgical wounds, Arch. Surg. 68:33 (Jan.) 1954. (Bellevue Hospital, New York, Third Surgical Division—Dr. John Mulholland, chief).

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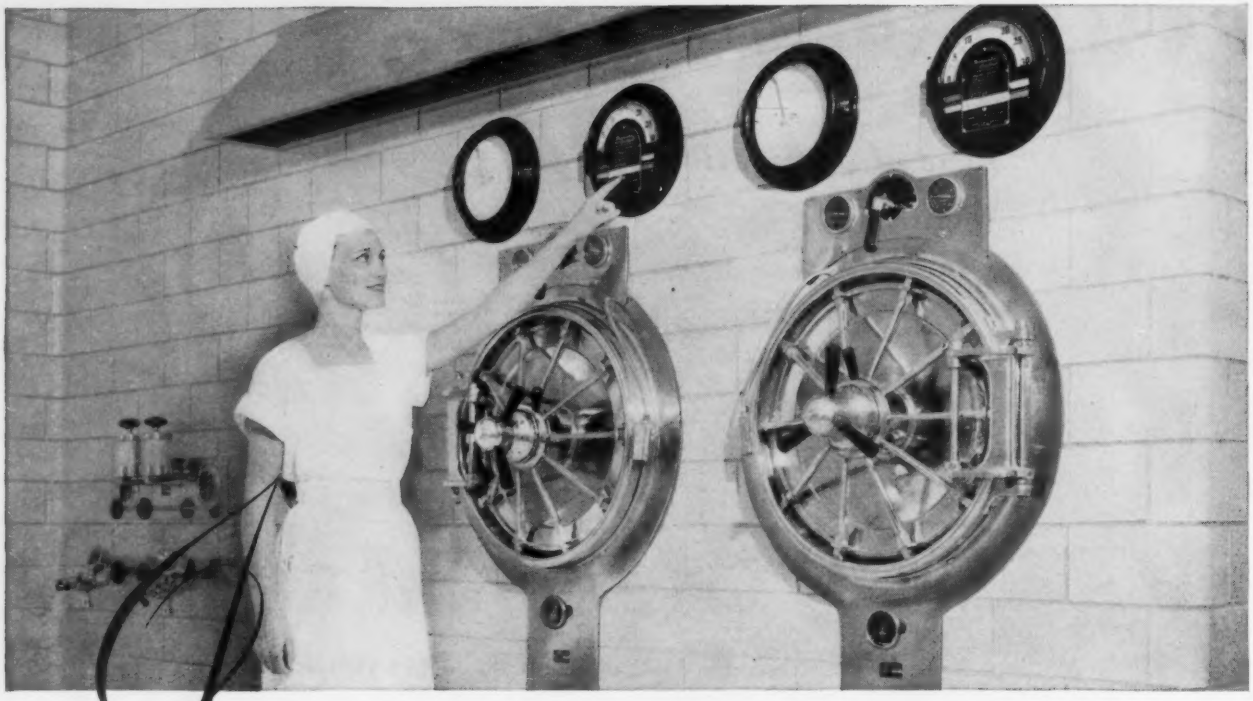

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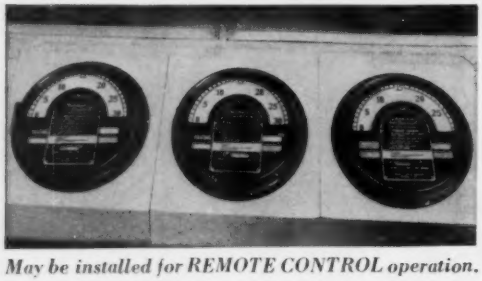

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The Occupational Therapist in Pediatrics

By Lena Hitchcock, O.T.R.*

● The occupational therapist in pediatrics, because of her peculiar relationship to the child, is frequently able to furnish clues to otherwise baffling causes of psychosomatic illness, feeding, behavior, and other problems.

Her value ascends in proportion to the degree of the institution's inclusion of her in the professional team. She should participate in staff discussions concerning the patient, and receive full written diagnoses and instructions from the physician. Her daily records and progress reports should be attached to the patient's chart.

An efficient method of utilizing the O. T. to maximum capacity is in use in the University of Illinois Research and Educational Hospital's Department of Pediatrics.[1] The therapist interviews the parents when the child is admitted. Using a prepared form to be attached to his chart, she records such information as:

The name the child likes to be called

Language he best understands

Special eating likes and dislikes

Feeding schedules

Whether or not he feeds himself

Times of elimination and terms used to refer to it

Nap

Favorite playthings

Does he play alone? With other children? With siblings? With adults?

There is space for remarks by the nurse concerning attitude of parents, for further information concerning anything else needed to be known to keep him happy and contented, and for remarks by the O. T. and her signature.

A basic principle equally applicable to adult or child patient, is never directly to order his participation in a prescribed activity but to inculcate in him a desire for activity. To achieve this the therapist must first gain his confidence, ascertain his hidden creative longings, and evaluate his social relationships and intellectual ability. Within the frame of these and the physician's prescription, the patient's age and desires, his intellectual and physical limitations, the therapist prepares a variety of activities for his choosing, thus subtly persuading his cooperation.

In no type of institution has the O. T. been found more valuable than in pediatric hospitals. There especially, the nurse should find in her an ally and dependable assistant.

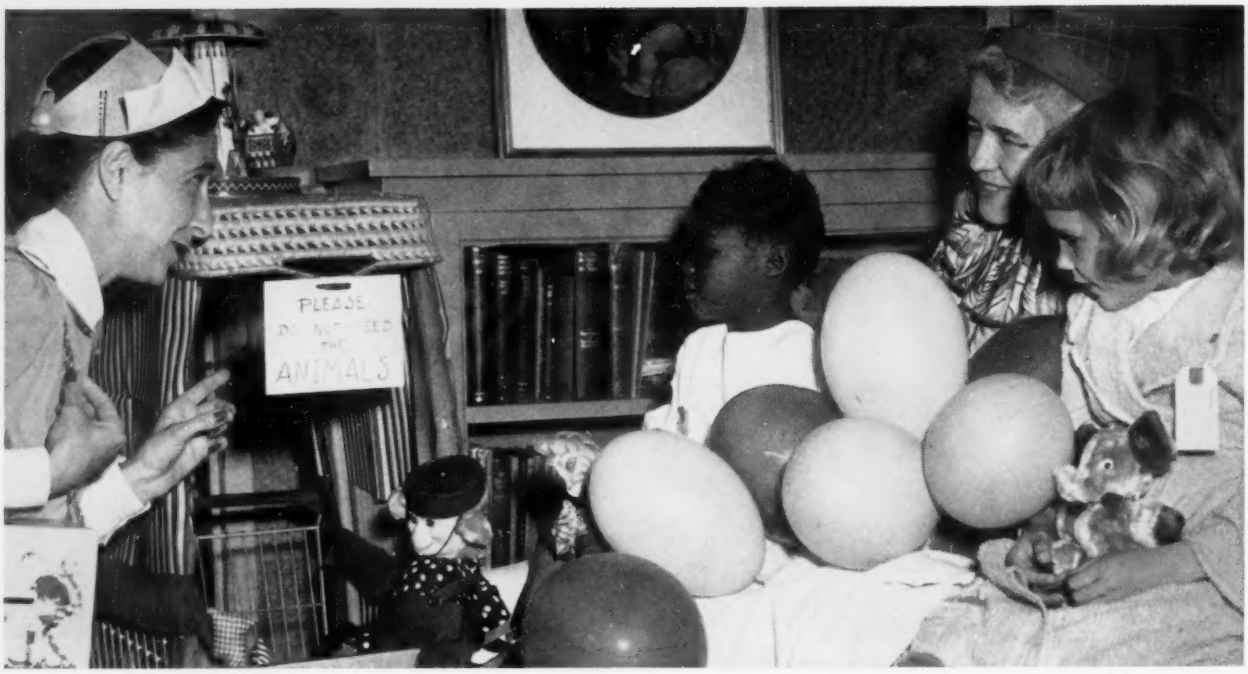
All who are ill tread a lonely road. This is very true of the sick child. The shadows of pain, new environment, and unknown people are strange and fearsome. If he meets

(Continued on next page)

Below: A Red Cross Grey Lady volunteer plays with three crippled children in the O.T. Workshop at The Children's Hospital, Washington, D.C. Volunteers, trained by therapists, can be a great help in pediatric wards.

*Miss Hitchcock is director of occupational therapy, D. C. Society for Crippled Children, Washington, D. C.

1. Poucher, Henry M., M.D., and Richmond, Julius B., M.D., "Occupational Therapy and Pediatrics," *American Journal of Occupational Therapy*, Vol. I, No. 5, 1947.



Above: Parties are great morale builders and birthdays and holidays must always be celebrated. The picture above was taken at a May party held in the O.T. Department, Children's Hospital, Washington, D.C.

compassionate understanding and merry hearts, it will make all the difference. In addition to her trained technical knowledge and skills, sense of human and professional responsibility, talent for co-operation, and attention to orders, the O. T. working with children should possess certain other imperative and dynamic attributes. She must inherently like and respect children as individuals. She must have inexhaustible patience, a sense of humor, an objective and subjective imagination, and a distinct memory of her own childhood reactions, plus resourcefulness and ingenuity. She must also be well grounded in the concepts of child psychology. During duty periods she must be able to subordinate completely her own personal anxieties and preoccupations in order to concentrate entirely upon the child's problem and to respond to his needs.

The ability to impose wise, gentle, firm discipline implies self-discipline. The disciplined child is secure, and proper discipline is vitally necessary during illness. If he is constantly aware of complete justice, tenderness, and liking for him, he will, without resentment or emotional trauma, sink into it as into his bed when weary of play.

All activities presented to the child must be interesting and a source of fun. The choice, even within prescribed boundaries and medical categories, is wide. The limitless horizons of imagination may be reached via "make-believe," acting out a favorite story, story-telling, and songs. In all these, spontaneity should be encouraged. Even to the bed-bound, group play is possible and often advisable, except in certain isolated instances. However, the O. T. must always be alert for signs of fatigue. As a matter of general procedure, she should set a limit of minutes on all activity, whether active or passive, until the child's total endurance span has been carefully noted and charted.

A stock of odds and ends, colored and metallic paper, round curtain rods, ribbon, string, paper bags, gay fabrics, and paste should always be available in the storage cupboard. From these, marvelous properties can be manufactured, such as space helmets, Davy Crockett hats, crowns, scepters, flower wreaths and May poles. Even a very sick child, bed-bound or immobilized, may thus dress up and pretend. If he is able to make these properties or a part of them, the benefit is greater. When organic or functional impairment is present, all activities must be correlated and considered in direct relation to corrective potentials.

Below: The author plays "Reach and Grab" with a little crippled boy preparatory to teaching him self-help skills such as buttoning, lacing shoes and feeding himself. This picture was taken several years ago; the little boy is now able to do many things for himself.

Detested food may be accepted and palatable if called by a fairy name, especially if it savors of magic or adventure. Serve the child "pemmican," and he is an Arctic explorer or downed flier. Milk with a few drops of vanilla or coloring becomes "ambrosia."

Then there are gardens, not those from a florist, but his own. Equipment is simple, consisting of small oblong, square, or round, tin pans, a light spoon, fork, and tiny pitcher from the dime store, pebbles, cupfuls of earth, a packet of seeds. To make the garden, punch holes in the pan's bottom, place in it pebbles and earth, hollow with spoon or small finger for the seeds. The earth is then smoothed over, and water poured from the pitcher. The pan is placed on a table near a window but brought to the child each day for tending. The fork is used for loosening the earth. Watching life grow engenders a subconscious desire to live.

The garden may be further embellished with a small pocket mirror for a pond, gay pebbles, shells, a log cabin built of twigs, an Indian wigwam of twigs and an old glove. These are all magic.

A fairy boat is concocted from a medium-sized scallop shell with toothpick mast and ribbon sail. A drop of cement fastens it to a pocket mirror. Acorns are fashioned into tea sets and tiny tops. An old shoebox and a roll of paper scenery fastened to empty adhesive tape spools for winding will create a stage. Other simple bed-bound projects include fans made from swab sticks and crepe paper, bowls from ribbon confetti, paper plate and crepe paper woven handbags, tray decorations and favors from colored paper, tongue depressors, and pipe cleaners.

Birthdays and holidays are important and should always be celebrated. Therefore, the storage cupboard should also contain candles, the makings of valentines, cards, and Christmas tree decorations. Cuddly toys should be easily available to fill the place of the beloved bear or bunny left at home. A few small, inexpensive toys and books should be there for special gifts.

Where will all these things come from? The volunteer helpers previously trained and motivated by the O. T. and for whose performance she is responsible, are all grateful for such an opportunity.

For ambulant children, the choice of activities widens. When space permits, a corner should be set aside for free play. It may be separated from the ward by a low set of shelves where toys, blocks, books, paints, crayons, paper pads, a tea set may be stored. The furniture of this playroom consists of a low table and chairs, a dollhouse, doll, and doll carriage.

Ambitious projects involving tools, bicycle saw and large looms prescribed for various orthopedic disabilities, should be relegated to the occupational therapy workshop; the floor looms, toys, and general functional equipment to the larger adjoining room. Both rooms should be spacious and uncluttered, with walls painted a soft cheerful color, and with adequate day and artificial lighting.

Color is important to children. It might therefore be advisable for the therapist working with them to consider exchanging her starchy white uniform, which in the child's mind is so often associated with pain, for one of a pale but gay shade.

Finally, the O. T. must recognize that second only to the physician the nurse is the supreme ward authority and cheerfully accept such authority. She must see herself as an integral part of the willing, eager, complex team dedicated to the care of the sick child, working as one to return him whole in mind and body to his place in the outside world.

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(Reports from the AMA meeting, Atlantic City, June 6-10, 1955)

Obstetrical Anesthesia Often Neglected Part of Specialty

System for Providing Hospital 24-Hour Service Described

Some of the best hospitals in the country provide their maternity patients with a quality of anesthetic service which would never be tolerated in their operating rooms. Obstetrical anesthesia is often an unwanted and neglected portion of anesthesiology.

Possible reasons for this are the scarcity of anesthesiologists, the passive attitude of anesthesiologists toward this phase of their specialty, the argument that obstetrical anesthesia, because of its emergency nature, encroaches unduly upon the anesthesiologist's time, and the lack of remuneration commensurate with the services rendered.

We believe it is practical to provide 24-hour medical anesthesia service to obstetrical patients. Since 1951 a group of anesthesiologists has provided such service to Tacoma General Hospital, a 215-bed private hospital with approximately 2,500 deliveries a year. The group, which also provides service to several other institutions, now includes seven anesthesiologists, eight residents in various stages of training, and three interns who are on anesthesia service for a minimum of six weeks.

Four attending anesthesiologists and four or five residents are assigned to Tacoma General Hospital, which in 1954 had 3,379 surgical operations and 2,359 deliveries.

On a typical day, three or four of the attending men and four residents will be on duty until the elective surgery schedule is completed. Since usually only four of the five operating rooms are used at any one time, three anesthesiologists generally are available for obstetrical use.

After the elective surgery schedule is completed, at least three anesthesiologists are available for obstetrics and emergency surgery. The three on call usually consist of one attending anesthesiologist, one second-year resident, and one first-year resident.

If there is no activity in the labor room, the attending man goes home but remains on consultation call. The anesthesiologist on first call sleeps on the obstetrical floor, so that he is available within two or three minutes, and the one on second call also remains in the hospital.

In 1954, residents administered about 20 percent of obstetrical anesthetics alone.

If more than three anesthesiologists are needed, the persons on first and second call in one of the other local hospitals may be summoned. Although each anesthesiologist is on call about every third night, the schedule is not too difficult, since the one on first call is off the next morning. The person on second call may be called once or twice during the night, while the person on third call is not usually called after midnight, except for consultation or in case of complications.

Whenever possible, an obstetrical patient is seen before anesthesia is administered, so that a history may be obtained and the patient's preference of anesthesia determined. The decision as to the optimum time of initiating analgesia usually is made by the obstetrician, but may be left to the anesthesiologist, especially when a continuous block is to be used.

The anesthesiologist supervises the administration of restorative fluids and drug therapy to the mother, and assumes care of the newborn. In the postpartum period he sees the patients daily and takes an active part in preventing and treating postanesthetic complications and managing respiratory problems in the infant.

When visiting patients, he wears street clothes, so that they will not think of him as one of the house staff.

The obstetrician is often at fault in accepting the barest minimum of anesthetic service. He should demand that the anesthesiology department be organized to give the obstetrical service expert anesthesia at any time.—**John J. Bonica, M.D.**, Tacoma, Wash.

Multiple Cesarean Sections Apparently Do Not Mean Increased Hazard

Prematurity Risk Greater, But Mortality Not Higher

Providing the integrity of the uterus is maintained, it seems that the number of cesarean sections can be unlimited.

The risk of prematurity is greater in patients having multiple sections, but the danger of maternal and fetal mortality is not increased.

A survey was made in 18 American and two Irish hospitals of 130 patients who had had four or more cesarean sections. There were 464 previous sections among the 130, 44 previous vaginal deliveries, and 638 babies born.

There was one maternal death in the entire series. This patient had had one vaginal delivery and three low segment sections for contracted pelvis, and presented a large incisional hernia. The surgeon repaired the hernia after a repeat low section was performed. The patient died as her skin was being sutured, but the baby survived. Cause of death was not discovered.

It seems to be in the best interest of both mother and baby to perhaps operate a little early and run the calculated risk of prematurity.

Over one-half (55.38 percent) of all patients had general anesthesia with the last section, and only two cases (1.54 percent) received local anesthesia. We believe local or spinal anesthesia is better for both mother and baby, because of the great risk of prematurity.

(Continued on next page)

Previous postoperative infection does not always cause subsequent weakness of post-section scars, but does contribute to such weakness in some cases.

Distention of the uterus by an advancing pregnancy as a cause of weakened scar and/or rupture is more to be feared than labor. The danger of a ruptured uterus is greatest before but near term in the absence of labor.

Because most of the previous operations were of the low segment variety and most hysterectomies followed the classical type operation, the laparotrachelotomy contributes less to weakened scar and/or rupture.

Hysterectomy in a multiple section patient should be performed only when the uterus is judged clinically pathologic and when it cannot, in the operator's opinion, stand the distention of another pregnancy.

Forty-eight of the patients, or 36.92 percent, were between 31 and 35 at the time of the last section, and 37, or 28.46 percent, were between 36 and 40.

No conclusion was reached concerning the relative safety of vaginal deliveries following cesarean section.—**Hugh B. McNally, M.D.,** Baltimore.

County Maternal Mortality Study Becomes Statewide

● A continuous annual maternal mortality study which has been conducted in Franklin County, O., from 1948 through 1954, is now to be on a statewide basis, under the auspices of the Ohio State Medical Association.

Results of the county study, which was under the sponsorship of the Columbus Obstetric-Gynecologic Society, were reported in an exhibit at the 1955 AMA meeting by Richard L. Meiling, M.D., and Anthony Ruppersberg, Jr., M.D., both of Columbus.

Heart disease is playing a hitherto unsuspected role in maternal mortality, they pointed out.

Of the 121 cases studied, 82 were classified as maternal deaths. Considering the 82 maternal deaths with 101,694 live births reported for the seven-year period, a maternal mortality rate of 0.806 per thousand live births is revealed, compared to 1.5 per thousand in 1947, before the survey started.

Principal causes of mortality—hemorrhage, infection and toxemia—were each reduced more than 19 percent during the period of the study.

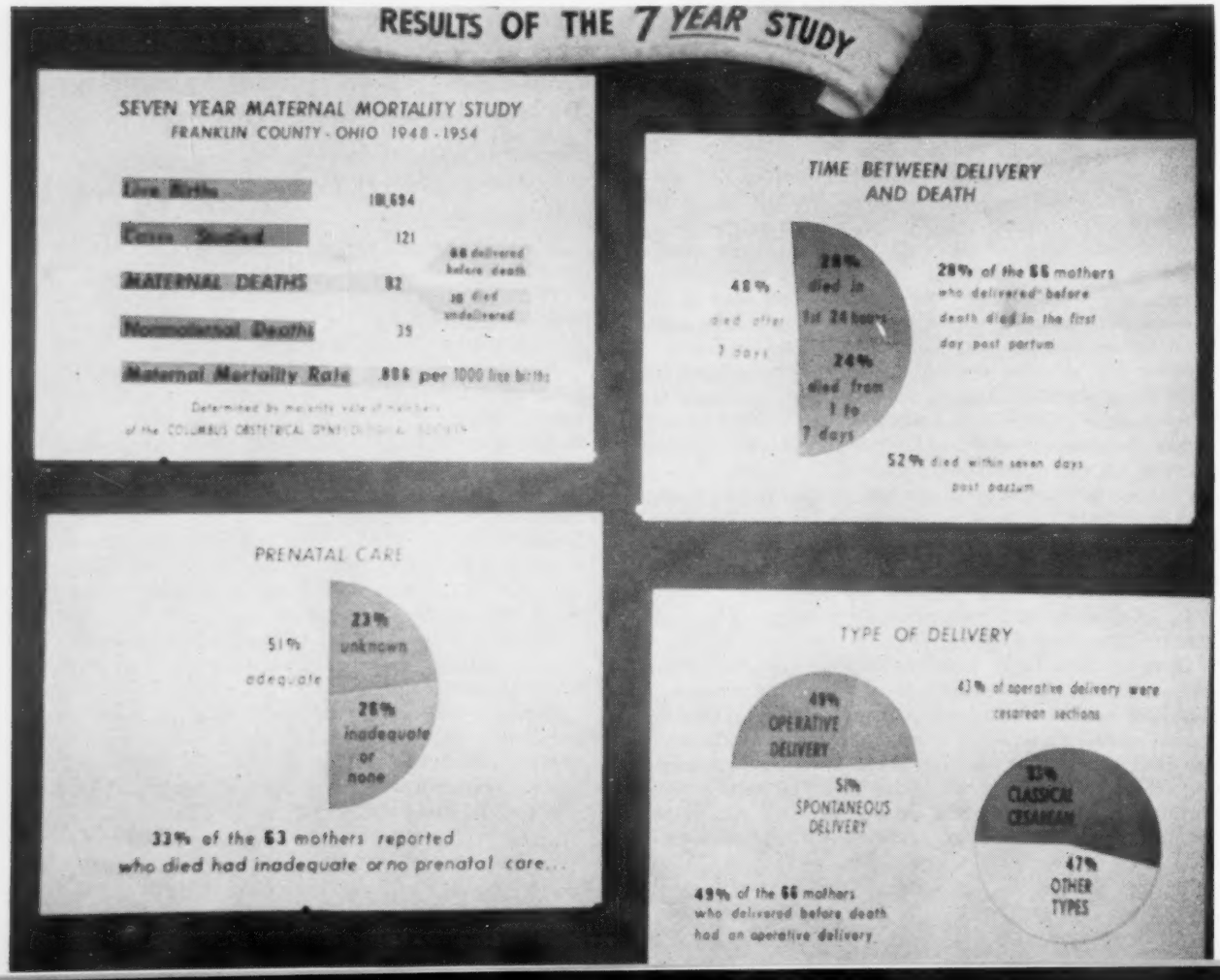
Cooperation of hospital administrators, house staffs, and record room personnel was essential for the success of the study, Dr. Meiling and Dr. Ruppersberg said. They credit the medical record librarians with much of the success of their efforts. The librarians pull the charts on all maternal deaths.

The questionnaire used to collect data is a modification of the one used by the Children's Bureau of the U.S. Department of Labor.

The study, its originators declare, shows a need for further education in obstetrical problems, including early diagnosis of complications and adequate prenatal care.

There is also a distinct need, they emphasize, for more accurate and complete records on the obstetrical patient—in the physician's office, in the hospital, and on the official birth and death certificates.

Some of the principal results are shown in the picture below.


RESULTS OF THE 7 YEAR STUDY
SEVEN YEAR MATERNAL MORTALITY STUDY
FRANKLIN COUNTY - OHIO 1948 - 1954
Live Births
101,694
Cases Studied
121
MATERNAL DEATHS
82
66 delivered before death
16 died undelivered
Nonmaternal Deaths
39
Maternal Mortality Rate
.806 per 1000 live births
TIME BETWEEN DELIVERY AND DEATH
48% died after 7 days
28% died in 1st 24 hours
24% died from 1 to 7 days
28% of the 66 mothers who delivered before death died in the first day post partum
52% died within seven days post partum
PRENATAL CARE
51% adequate
23% unknown
26% inadequate or none
33% of the 63 mothers reported who died had inadequate or no prenatal care...
TYPE OF DELIVERY
49% OPERATIVE DELIVERY
51% SPONTANEOUS DELIVERY
43% of operative delivery were cesarean sections
53% CLASSICAL CESAREAN
47% OTHER TYPES
49% of the 66 mothers who delivered before death had an operative delivery

The Book Corner

Patterns of Patient Care

By Frances L. George, R.N., M.A., and Ruth P. Kuehn, R.N., Ph.D. Published by the Macmillan Co., New York. 266 pages. This study, conducted by the University of Pittsburgh Nursing School, is a great step forward in solving the problem of providing adequate nursing service for hospital patients.

Miss George, professor of nursing education, and Mrs. Kuehn, professor and dean of the school, have studied the question of how much nursing service is required by a group of non-segregated medical and surgical patients in a large general hospital. An analysis is made of the functions which can be delegated to non-professional personnel such as the ward clerk and the nurse aide. Methods of preparing and utilizing personnel to the best advantage are suggested.

As a part of the study, the research team devised a staffing pattern for assigning personnel. This master schedule assures a fair distribution of personnel to various tours of duty and permits preplanning of days off duty.

A series of charts show samples of an activities check list for nurse aides, personnel policies and practices for nurse aides, samples of sheets used in allocation of activities for various grades of personnel, and a statistical survey of basic nursing activities arranged according to frequency of occurrence.

Acquiring Surplus Property For Health or Educational Use

Prepared by the U.S. Department of Health, Education, and Welfare. Published by the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C. 15¢. This pamphlet has been prepared as a guide to those who wish to acquire surplus property for health or educational purposes. Included are sections on the differences between real and personal property, who is eligible to acquire the property, the proper method of making applications to state agencies, and the conditions and restrictions on disposals.

A regional and state agency directory lists names and addresses of directors of agencies in charge of surplus property.

Women's Auxiliaries In Hospitals Guide

Published by the United Hospital Fund of New York, New York City. 67 pages. $1. "A Guide to the Organization of Women's Auxiliaries in Hospitals," is written so that it may be used as a text for hospitals that wish to establish an auxiliary group, as an aid for those who wish to modernize or expand the work of an existing auxiliary, or as a reference book for those who seek a solution for a particular problem.

Model by-laws for a women's auxiliary, with commentary explaining the reasons for each provision, and a bibliography are included.

The illustrated booklet shows the relationship between the hospital board of trustees, administration, and the women's auxiliary. It also points out the proper method of coordination among the three facets.

Also discussed are the many committees recommended for a women's auxiliary and details of the work of such committees. These include membership, finance, fund raising, public relations, legislative, medical social service, patient's library, occupational therapy, linen supply, art for hospitals, and volunteer services.

The Medical Significance Of Anxiety

By Richard L. Jenkins, M.D. Published by The Biological Sciences Foundation, Ltd., Washington 7, D.C. $1. The need for the control of anxiety and its relation to the practice of medicine is a subject that has been greatly neglected, according to Dr. Jenkins, chief, psychiatric research, VA Psychiatry and Neurology Service.

In his new booklet he points out that the problem of dealing with a patient's anxiety must be recognized as an integral part of medical treatment.

Dr. Jenkins discusses the physical manifestations of anxiety in the skeletal structure and in cardiovascular, gastrointestinal, respiratory, and urinary symptoms. One portion of the book is devoted to conversion reactions—psychogenic illnesses in which anxiety is converted into physical symptoms.

The author advises the physician to bring the patient's anxiety under control and then reorganize his way of thinking so that a recurrence of "runaway" anxiety is unlikely. Sensitivity and understanding on the part of the physician are essential, so that the patient may have confidence in his doctor and understand the nature of his illness and the measures being taken for its correction.

Another section of the book deals with the neurophysiological processes in anxiety and emotional stress.

TRADE TOPICS...

Abbott Laboratories recently announced three promotions. Pictured above are (l. to r.): Dr. Arthur W. Weston, George R. Ryan, and Elmer O. Krueger. Dr. Weston, formerly of Abbott's research division, has been named assistant director of development. George R. Ryan was promoted to the post of assistant director of packaging. He formerly was assistant to the director of production. Elmer O. Krueger has been named director of control and put in charge of the entire Abbott inspection and testing program. He formerly was manager of the control laboratories.

Anton Maria von Girardi Heads Propper Foreign Office

The Propper Manufacturing Co. has opened an office in Tuttlingen, Germany, under the direction of Anton Maria von Girardi. The new office is a result of the growing trade with leading German manufacturers of quality surgical instruments.

Mr. von Girardi besides being well known in the surgical supply field in German circles, is a noted author, playwright, and actor listed in "Who's Who in Germany." As a resident representative of Propper, he will travel throughout Europe as director, consultant, and purchasing agent of the company, and will use the permanent offices at Tuttlingen as headquarters.

Taylor Occupies New Plant

Taylor Instrument Companies recently moved its San Francisco plant and sales office across the Bay to new quarters at 1661 Timothy Drive, San Leandro, Calif.

Diversey Corporation Promotes Three Men

Three men have been appointed to new posts with the Diversey Corporation. J. A. McMurtry, formerly assistant general sales manager, has been named division manager for the newly created east central division. C. R. Reid has been promoted to sales manager, food industries, and H. M. Pickles has been appointed assistant to the sales manager, food industries.

The Diversey Corporation is a leading manufacturer of specialized sanitation and maintenance chemicals for the food, beverage and institutional fields.

Hyland Laboratories Announces Promotion

John W. Palmer, Ph.D., has been named to the position of vice president, and treasurer, Hyland Laboratories. He was also named to the company's board of directors.

Dr. Palmer was previously associated with E. R. Squibb & Sons in production, development and research work in biological fields. He joined Hyland in 1952.

Norelco Appoints New Sales Engineer

Philip I. Wolf has been appointed resident sales and application engineer, research & control instruments

Pharmaceutical Advertising Clubs Adopt 10-point Code of Ethics

A 10-point code of ethics governing the preparation of medical advertising and sales promotion material was adopted unanimously by the board of directors of the Pharmaceutical Advertising Club of New York and the Midwest Pharmaceutical Advertising Club at a joint meeting during the recent AMA convention.

The 10 points of the code, presented by G. L. Long, advertising manager, Mead Johnson & Co., are:

1. Pharmaceutical advertising should not, by intent or inference, defraud, deceive, or mislead the reader. Any statement of fact should be accurate and supportable by adequate and acceptable scientific evidence. Any statement of rationalization or speculation should not be presented as a fact—stated or implied.

2. Any statement made in pharmaceutical advertising should be believable and provable. Adequate and objective evidence should be unquestionable. Advertising should not exceed claims which are supportable by such evidence.

3. A pharmaceutical advertising program should give a proper perspective of a product's role in patient management, such as: properties, indications, limitation of use, advantages of use, advantages and disadvantages.

4. Quotations or excerpts, abstracts or paraphrasing from published medical papers or texts, personal communications, scientific exhibits, or speeches shall not by themselves change or distort the true meaning intended by the authors. Such material shall not be used if it is not consistent with later known findings, observations, or conclusions of the authors or investigators. Such material shall not be cited as representing general medical opinion if it reflects a point of view held only by an individual worker or group.

5. Comparisons with competitive pharmaceutical specialties, aimed at establishing product superiority, are fair and proper if: such comparisons are supported by acceptable evidence; such comparisons are constructive and on a sound medical basis; such comparisons do not refer disparagingly to the safety of the competitive product.

6. A trademark is private property, and it can be used legally only with the consent of the owner of the mark.

7. The medical profession should be given information on the clinical use of a new drug, or a new use for an established drug, before the release of such information to the lay public.

8. Prescription drugs should not be advertised to the lay public.

9. Statements by a physician should not be used in advertising to the lay public.

10. Physicians, or actors purporting to be physicians, may appear in institutional advertising to the lay public, but not in product advertising to the lay public.

division, North American Philips Co. His job will cover the western part of the United States.

Mr. Wolf will assist Philips sales representatives with technical application problems on electron microscopes and other Philips equipment.

Install New President of A.P.M.A.

Kenneth F. Valentine, president, Pitman-Moore Co., Indianapolis, was installed as president, American Pharmaceutical Manufacturers Association, at its annual meeting in White Sulphur Springs, W. Va.

He is a director, National Pharmaceutical Council, as well as a member of the Council on Chemistry and Pharmacy Rules, a director of the Health Information Council, and a member of the Drug and Pharmaceutical Committee, National Fund for Medical Education.

Above: Mary Jean Sullivan and Albert Miles Donnell receive the American Surgical Trade Association Awards from Frank Rhatigan, director of the association. The award, established in 1954, consists of two United States Saving Bonds, presented for high scholastic standing. The awards were presented at a Northwestern University pre-commencement reception held at Abbott Hall, on the Chicago downtown campus.

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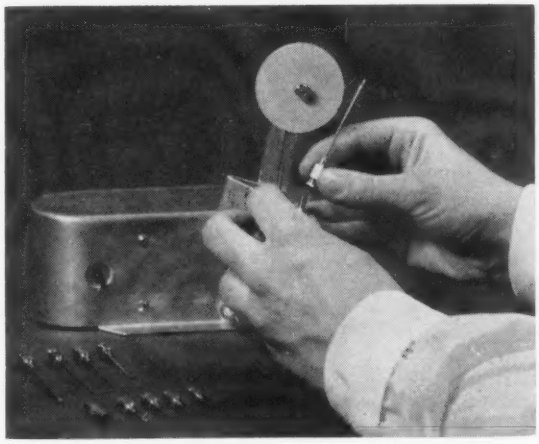

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Personally Speaking

University of Chicago students who recently completed a year's course in hospital administration are, front row (l. to r.): Robert A. Walker, Richard L. Durbin, Lyle N. Buckles, Denison K. Bullens, Jr., Henry Veldman; (second row) Richard D. Wittrup, Richard D. Gifford, David W. Clark, Warren G. Ball, M.D., James Paton; (third row) Philip K. Reiman, Richard L. Johnson, associate director of the program, Ray E. Brown, director of the program, and So Zimmerman, coordinator. For a listing of their appointments to administrative residencies, see page 63.

James H. Abbott—has assumed his duties as administrator, Hospital of the Good Shepherd, Syracuse (N. Y.) University.

Louis August—has been appointed administrator, Hutchinson Memorial Hospital, Oregon City, Ore. He formerly was business manager, Santiam Memorial Hospital, Stayton, Ore.

George J. Bartel—was appointed administrator, Monmouth Memorial Hospital, Long Branch, N. J. succeeding **Ira Ernst**, who resigned.

Jesse Bartlett—has been named administrator, Ivy Memorial Hospital, West Point, Miss., succeeding **Harry C. Cutler**, who resigned to assume management, Montfort Jones Memorial Hospital, Kosciusko, Miss.

Thomas H. Biggs, M.D.—has been named superintendent, Kentucky State Tuberculosis Hospital, London, Ky., succeeding **Jacob Heinrich, M.D.**, who resigned.

Edward H. Boyer, M.D.—has been appointed director of pathology and clinical laboratories, Osteopathic Hospital, Sharon, Pa.

Ben R. Brewer—has been named assistant administrator, Georgia Baptist Hospital, Atlanta, Ga.

Bruce Burton—has assumed management, West Seattle General Hospital, Seattle, Wash. He succeeds **Mrs. Jessie Morrison Anderson.**

Donald C. Carner—has been appointed administrator, Seaside Memorial Hospital succeeding **Irmela M. Witke** who retired.

Mrs. Hazel W. Carmichael—has been appointed executive housekeeper, Memorial Hospital, Wilmington, Del. She replaces **Mrs. Florence Gibbons** who retired.

Mrs. Nancy T. Carr—has resigned as dietitian, Glynn Brunswick Memorial Hospital, Brunswick, Ga. **Mrs. Hattie Beyer,** formerly a member of the dietetics staff, County Hospital, Tifton, Ga. will succeed Mrs. Carr.

E. L. Cavanaugh—has been named administrator, Bertie County Memorial Hospital, Windsor, N. C. He was formerly assistant business manager, Onslow County Hospital, Jacksonville, N. C.

Frank Ceruzzi—has been named administrator, Davie County Hospital, Mocksville, N. C. He formerly was administrative resident, Norfolk (Va.) General Hospital.

Lawrence N. Cheeley, M.D.—was appointed anesthesiologist, Oil City (Pa.) Hospital.

Anthony Constantine—has been appointed administrative assistant in charge of public relations and personnel, West Pennsylvania Hospital, Pittsburgh, Pa.

Carmelita Craven—has been appointed Texas state institutional nursing consultant. She formerly was supervisor of psychiatric nursing, VA hospital, Houston, Tex.

William J. Cremer, M.D.—has been appointed acting superintendent, State Hospital No. 1, Fulton, Mo., during the absence of **R. P. Price, M.D.**

William J. Daniels—has recently accepted the position of administrator, Hawthorne (Calif.) Community Hospital. He formerly was administrator, Los Companas Hospital and Sanitarium, Compton, Calif.

Rose DeWever—has been appointed director of nursing, Riverside Hospital, Newport News, Va. She was formerly director of nurses, Columbia (S. C.) Hospital.

B. E. Dillon—has been appointed administrator, Baxter Springs (Kans.) Hospital.

Jack Dillman—has been named assistant administrator, Weirton (O.) Hospital.

Albert M. Donnell—has been appointed administrator, McAlester (Okla.) General Hospital, succeeding **Vernon C. Walker.**

Joseph J. Doney—has been appointed administrator, Whitesburgh (Ky.) Memorial Hospital.

Eugene Glenn Edwards—has been named superintendent, Bryan Memorial (Methodist) Hospital, Lincoln, Nebr., succeeding **E. C. McDade, M.D.,** who is now field representative for the hospital.

Margaret Eliot, R.N.—director, Columbia-Presbyterian Medical Center nursing service, New York City, has retired.

Samuel E. Elmore, M.D.—has been elected chairman, medical staff, General Hospital, Spartanburg, S. C.

Raymond B. Farrell—has joined St. Francis Hospital, Hartford, Conn., as assistant accountant.

Howard Taft Fielder, M.D.—has been named superintendent, Allentown (Pa.) State Hospital.

Homer T. Ford, Jr.—was named assistant manager, John J. Cochran VA hospital, St. Louis, Mo.

C. R. Gallop — has been appointed Missouri state director of public health and welfare. He succeeds **W. Ed Jameson,** who retired on his 90th birthday.

Robert M. Gantt, Jr.—has been appointed administrator, North Broward General Hospital, Fort Lauderdale, Fla., succeeding **Frederick M. MacCurdy,** who resigned.

Dorothy Grabusic—has been appointed director of public relations, Episcopal Hospital, Philadelphia, Pa.

Robert E. Hamann—has been named controller, Presbyterian Hospital, Chicago. He succeeds **Glenn H. Pontious.**

Frank D. Hicks—has accepted a position with the Division of Biological Sciences, University of Chicago. He was formerly editor, *Hospital Management* magazine.

Edward N. Hinko, M.D.—has been appointed acting superintendent, Larue D. Carter State Hospital, Indianapolis, Ind., following the resignation of **Juul C. Nielsen, M.D.**

William Hunter—has joined the Claremore (Okla.) Health Center, as laboratory and x-ray technician.

Margaret M. Jackson—director of nursing service, and principal, school of nursing, West Pennsylvania Hospital, Pittsburgh, has resigned to assume similar responsibilities, Philadelphia General Hospital.

John Kingsley Lattimer, M.D.—has been appointed attending urologist, and director, Urological Service, Columbia-Presbyterian Hospital, and professor of urology and executive officer of that department, Columbia University, New York City. Dr. Lattimer succeeds **George F. Cahill, M.D.**

L. M. Letson—has been appointed administrative assistant, St. Francis Hospital, Lynwood, Calif.

Elmer Lohnes—has been appointed administrator, Community Hospital, Gibson City, Ill. He succeeds **John Shaw** who resigned.

Avery M. Millard—has resigned his position as assistant director in charge of the American College of Hospital Administrators institutes. He has accepted a position as executive director, California Hospital Association.

Ernest C. McKay—administrator, Tampa (Fla.) Municipal Hospital, has resigned. **Arthur G. Burns** has been appointed assistant superintendent there.

R. H. McKinnon—has been named administrator, Rutherford Hospital, Rutherfordton, N. C. He formerly was administrator, Lee County Memorial Hospital, Bishopville, S. C. **William J. Bishop** succeeds McKinnon at Lee County.

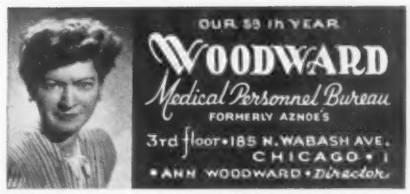
Dorothy Laverne McMillan—was appointed director of nursing, Waterbury (Conn.) Hospital succeeding **Ida M. Meier.**

J. Margaret Ada Mutch—has been named director, Lankenau Hospital, Philadelphia, Pa.

Russell L. Nichols, M.D.—has been named professor of radiology, and head, radiology department, Jefferson Medical College and Hospital, Philadelphia.

(Continued on next page)

WANTED: Instructor of Nursing Arts, with degree in Nursing Education and experience in teaching, for an accredited school of nursing, 70 students, 3 year program with college affiliation. General hospital, 236 beds, plus 60 bassinets; new wing addition to start soon. Pleasant working conditions, liberal personnel policies. Salary dependent upon qualifications. Write Director of Nursing, San Jose Hospital, San Jose, California.



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POSITIONS OPEN

ADMINISTRATORS: (a) Medical dir, gen'l hosp, 600 beds, affil several med schools; very attractive offer. (b) Lay or Medical; new gen'l hosp, 350 beds, med schl affil, soon to be completed; city 400,000. (c) Supt, TBc hosp lge size under construction; excel environment free of politics; very substantial sal & other advantages & emoluments; warm climate. (d) Ass't Supt, under 55, coll grad w/sev years exper; gen'l hosp very lge size; W-Coast. (e) Lay, Spanish speaking Catholic; impor hosp, 400 beds; tropical, university, seaport city 200,000 outside continental U.S. (f) Lay; gen'l hosp, 150 beds being completed; req's degree in hosp adm or equiv experience; attrac coll town 30,000; S. (g) Lay; 2 year survey; foreign country; 2 yr contract; no U.S. income tax; travel, living expenses; interesting. (h) Medical; well-eqp'd, beautiful 50 bed hosp; consider mature person, perhaps ex-army officer in semi retirement; small town, site of noted sch for boys; E. (i) Lay; new hosp, 125 beds; completion Fall, '55; S. (j) Lay; gen hosp, 100 beds recently completed; univ town 100,000; SW. (k) Lay; gen'l hosp, medium size; excel med staff of 40 M.D's. Calif. (l) Lay; new gen hosp, 100 beds; prefer southerner w/hosp course & exp'd; Mid-S. (m) Medical or Lay; vol. lge gen'l hosp affil impor med schl; E.

ADMINISTRATORS — (ASSISTANTS): (n) Adm service dir; gen'l hosp very lge size; req's coll degree, bus or public adm major, M.H.A. plus 4 yrs hosp adm work includ'g 2 yrs as ass't admin; to $12,000. (o) Two req'd; exp'd in purchasing, personnel req'd; gen hosp, 300 beds; Wash D.C. area. (p) Gen. hosp, 150 beds; replace man promoted to adm; univ town 15,000 short distance to Chgo. (q) Fairly lge hosp vicinity Detroit; req's adm & accounting exp with or without degree; $5000. (r) Gen'l hosp, 300 beds expanding to 600 beds; town 70,000; SE. (s) Gen'l hosp, 350 beds; JCHA; city 300,000; Md-E. (t) Gen'l hosp expanding to 250 beds; lovely town 50,000 nr San Francisco.

ADMINISTRATORS—WOMEN: (a) RN; sm gen hosp; sal & full mtce; lovely agric area; MW. (b) Lay or RN; 50 bd gen hosp; twn 10,000; N. England. (c) Lay or RN; 100 bd gen hosp, 2 yrs old; excel educ, cultural ctr; W-central. (d) Lay or RN; 40 bd gen hosp now under constr; attrac twn; MW. (e) Lay or RN; gen hosp, 75 bds; univ twn; SW.

POSITIONS WANTED

ADMINISTRATOR: 7 yrs, dir 300 bed hosp; 2 yrs, dir 400 bed hosp; active in hosp affairs; Member, ACHA.

ADMINISTRATOR—MEDICAL: M.D., Minn; 7 yrs teaching medicine; 5 yrs Med Dir university hospital.

ASSISTANT ADMIN: 29; B.S. (Commerce); M.S. (Hosp Adm); yr's hosp adm res, 900 bed univ hosp; married.

ANESTHESIOLOGIST: 33; med degree, Harvard; trn'd univ hosps; currently dir dept anes, import grp-clinic & ass't prof, anes; seeks hosp grp prtnrship on fee basis; Midwest, East, South.

COMPTROLLER: 32; several years, comptroller, 350 bed gen'l hosp; Member, NHAA; immed avail.

PATHOLOGIST: Dipl, both branches; well known to us and highly recommended; 8 years, dir of depts, several hosps (500 beds); early 40's.

PATHOLOGIST: Dipl, both branches; trn'd Cook County Hosp, Chgo; 4 years, assoc & pathologist, 2 very lge hosps;

PATHOLOGIST-ASSISTANT: Trn'd important clinical research center; Bd. elig; 3 yrs, path, lge, impor clinical lab; seeks assistantship; prefers teach'g hsp.

RADIOLOGIST: Med degree, Western Reserve; trn'd univ hosp; 5 yrs, chief, rad, 250 bed hosp; Diplomate; late 30's; prefers warm climate.

RADIOLOGIST: Dipl, both branches; 12 yrs, successful priv pract, radiology includ'g 7 yrs, dir, dept rad, 150 bed hosp; licensed Calif, Fla; prefers warm climate; early 40's.

Alvin B. Ortner, M.D.—has been elected president, medical staff, Jewish Hospital, Louisville, Ky.

William D. Parkinson—has been appointed chief, Malheur Memorial Hospital, Nysso, Ore. x-ray and lab department.

Joseph H. Powell—has been named administrative associate, Baptist Memorial Hospital, Memphis, Tenn.

Sister Margaret Ellen—has been appointed assistant administrator, Providence Hospital, Seattle, Wash., succeeding **Sister Calista**, who has retired.

Elliott C. Shull, M.D.—has been named chief of staff, West Jersey Hospital, Philadelphia, Pa. succeeding **H. Wesley Jack, M.D.**, who died recently.

Margaret Snyder—has been appointed associate director of nursing service, Washington (Pa.) Hospital.

Masaicki Tasaka—has been appointed administrative assistant, Highland Park (Ill.) Hospital. He formerly was office manager, Southshore Hospital, Aiea, Oahu, Hawaii.

W. Earl Tyler—has been appointed administrator, Mary Rutan Hospital, Bellefontaine, O.

Dirk Verhoeff, M.D.—has been appointed superintendent, Mecklenburg Tuberculosis Sanatorium, Huntersville, N.C., succeeding **H. L. Seay, M.D.**

Richard T. Wall—has been named administrator, Watauga Hospital, Boone, N. C., succeeding **Vance C. Holland.**

Kamma Ancher Wright—has taken over duties as executive housekeeper, Southern Baptist Hospital, New Orleans, La. succeeding **Mrs. Willard K. Tew.**

Daniel C. Wunderman, M.D.—has resigned as superintendent, Trumbull County Tuberculosis Hospital, Warren, O.

George Hawk, M.D.—69, chief surgeon, Lehigh Valley Railroad, and president-elect, Medical Society of Pennsylvania, died June 9.

Julius I. Klepper, M.D.—74, specialist in diseases of eye, ear, nose and throat, died June 15. He was chief, otolarynologist service, out-patient department, New York Polyclinic Hospital, New York City.

S. David Kramer, M.D.—63, poliomyelitis researcher, and former instructor at Harvard and University of Michigan medical schools died June 24.

Basilla B. Lipetz, M.D.—associate professor, Albany Medical College, and attending psychiatrist, Albany (N. Y.) Hospital, died May 26.

Oswald S. Lowsley, M.D.—70, internationally known urological surgeon, died June 4. He was a pioneer in the surgery of genitourinary organs under local and regional anesthesia.

Henry Poncher, M.D.—53, former chief of pediatrics, University of Illinois, died May 31. He was a national authority on children's diseases.

Walter H. Siehl, M.D.—66, former president, Ohio Osteopathic Association, died May 29.

Alexander Sinclair, M.D. — Sault Ste. Marie, Ont., Canada, known for his work in thyroid surgery died May 29.

Deaths

C. H. Bernard, M.D.—52, chief radiologist, Children's Hospital, Akron, O., died May 20.

Sister Mary Columbkill—67, supervisor, medical division, Mt. Carmel Hospital, Columbus, O., died June 18.

George Allen Dicus, M.D. — 91, Streator, Ill., who was designated the outstanding medical practitioner in Illinois for 1954 died June 9.

Mrs. Mark Fleming—72, former president, New York Counties Registered Nurses Association, died June 3. She was chief surgical nurse, Bellevue Hospital, New York City.

George J. Greene, M.D.—51, city police surgeon, Cleveland, O., died June 4.

Philip Grossblatt, M.D.—53, gynecologist, Medical Tower, Newark, N. J. died May 26. He was an assistant in gynecology service, Beth Israel Hospital, Newark.

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DIRECTORS OF NURSING: (a) Southeast. 150 bed general hospital; all graduate staff. Degree required. Age to 55. $6000. (b) Southwest. 325 bed hospital; no nursing school. Degree in nursing education plus five years experience in supervisory capacity. $7200. (c) East. Assistant to Director. 300 bed hospital; part of a medical center associated with a university school of medicine. Will be responsible for graduate staff development and coordinating affiliated programs. (d) Director of Nursing Education. East. Will have complete direction of nursing school; 9 in dept. $6000.

MEDICAL RECORD LIBRARIANS: (a) CHIEF. California. 200 bed hospital in town of 25,000. Record room is new with all modern facilities: competent staff of assistants. $450. (b) CHIEF. East. 175 bed hospital. 3 in record room. (c) East. Teaching hospital. Unit record system. 1 assistant and 3 typists in dept. $375. (d) CHIEF. 400 bed hospital in historic southern city of about 100,000. 8 employees in dept. $400. (e) Middle West. 130 bed hospital in summer resort area not too far from Chicago. 3 well trained secretaries in dept. $350, plus maintenance. (f) CHIEF. East. 400 bed hospital. Organize and direct very active record department. $425.

PHARMACISTS: (a) CHIEF. South. Full charge of department in 200 bed hospital; one assistant pharmacist. $5000. (b) CHIEF. East. 300 bed hospital in suburban community near New York City. $5000. (c) Assistant. East. 450 bed hospital. $4500. (d) Middle West. 300 bed hospital affiliated with University. Can continue education if desired at very reasonable cost. 3 registered pharmacists in dept. $4800.

NOTE: We can secure for you the position you want in the hospital field in the locality you prefer. Write for application—a postcard will do. All negotiations strictly confidential.

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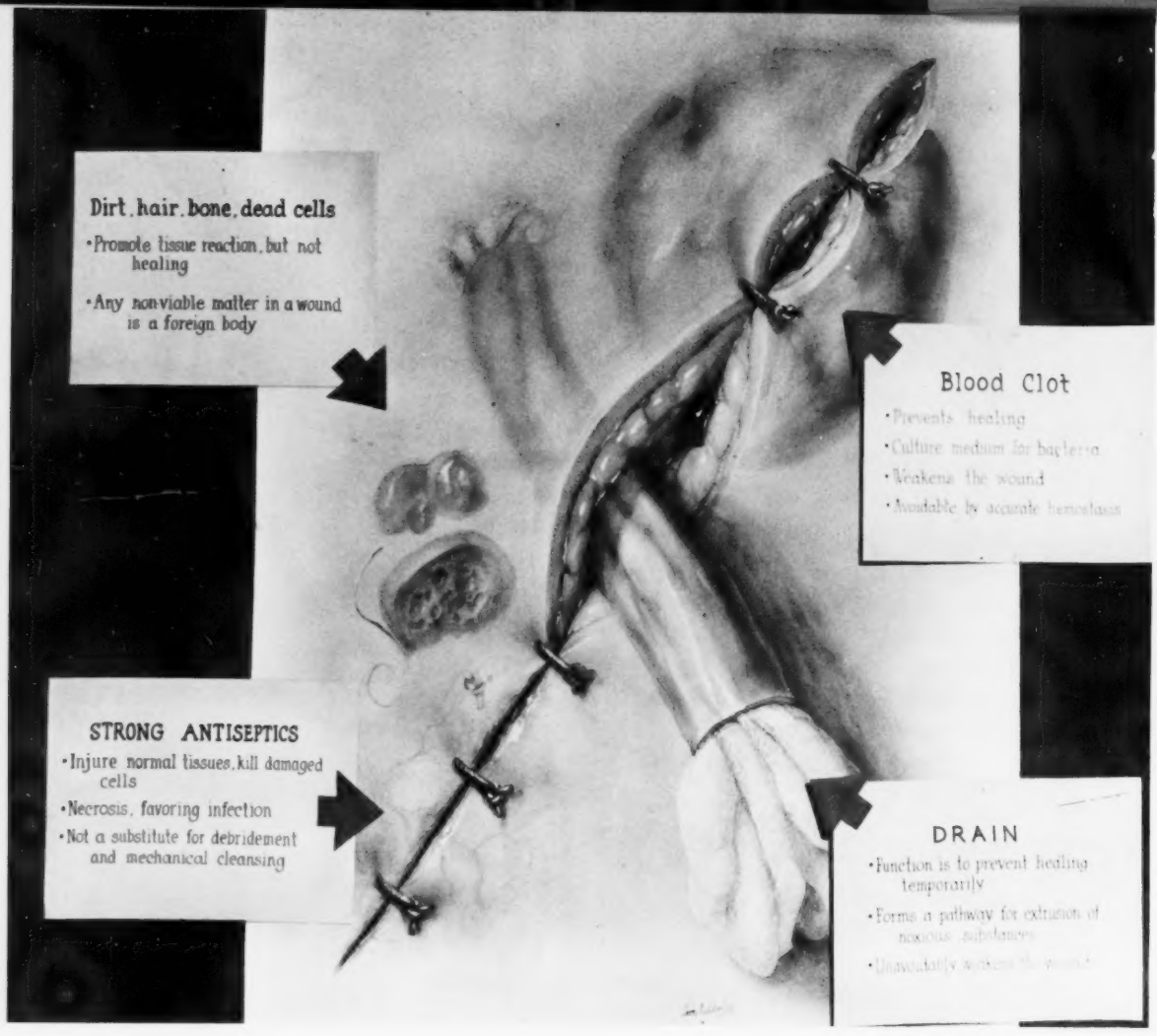
AMA

Scientific Exhibits

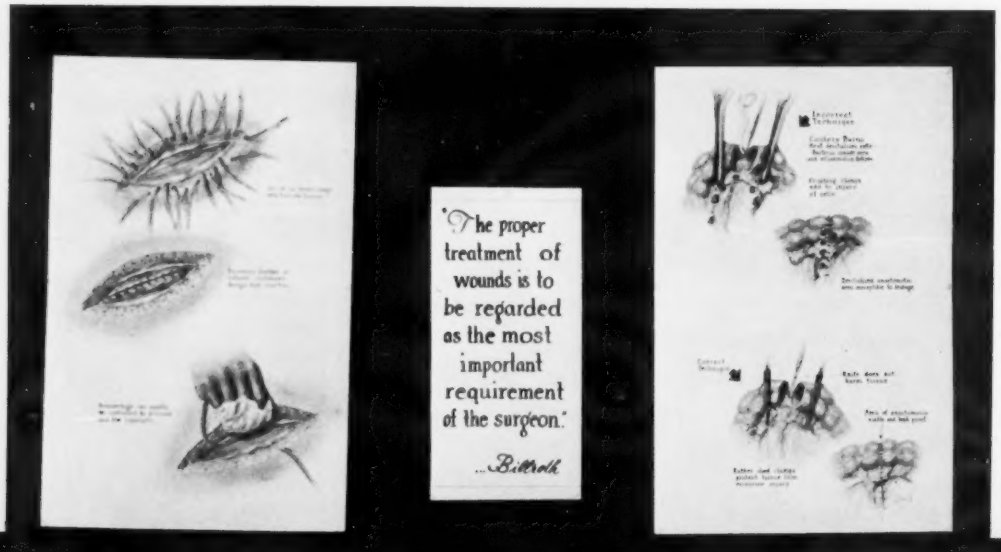
More than 11,000 physicians gathered at Atlantic City for the 104th annual meeting of the American Medical Association. In its usual impressive fashion the Scientific Exhibit section played to standing room only attendance. Here, especially prepared for readers of this magazine, is an eight-page graphic report showing some of the outstanding exhibits. The AMA will prepare and Grune & Stratton will publish this fall, 150 of the 350 exhibits in book form.

Chairman of the Council on Scientific Assembly this year was Dr. Alphonse McMahon, St. Louis. The commanding general of both the Scientific Exhibit and the scientific program was Dr. Thomas G. Hull, secretary of the Council. At left, he awards an honorable mention certificate to "Structure and Dynamics of the Human Epidermis," by Hermann Pincus and Catherine Heise Steele, Detroit Institute of Cancer Research and Wayne University College of Medicine, Detroit.

Dr. William B. Condon, Denver, awards committee chairman, stopped on awards tour to pay special recognition to "youngest exhibitor"—Foy Devine—who helped his father at exhibit on "Removal of Swallowed Objects from the Stomach by Use of Two Magnets," by J. W. Devine and John W. Devine, Jr., Lynchburg, Va.


Dirt, hair, bone, dead cells
•Promote tissue reaction, but not healing
•Any non-viable matter in a wound is a foreign body
Blood Clot
•Prevents healing
•Culture medium for bacteria
•Weakens the wound
•Avoidable by accurate hemostasis
STRONG ANTISEPTICS
•Injure normal tissues, kill damaged cells
•Necrosis, favoring infection
•Not a substitute for debridement and mechanical cleansing
DRAIN
•Function is to prevent healing temporarily
•Forms a pathway for extrusion of

The fundamentals of wound healing were presented graphically in an exhibit by Philip A. Caulfield and Howard S. Madigan, Georgetown University Medical School, Washington, D. C. Colored illustrations showed various errors in surgical technic that cause interference with wound healing.



Proper use of materials at hand: adherence to fundamental precepts of technique: avoidance of obstacles to wound healing ...

"A thorough knowledge of wound healing will lead to a more intelligent practice of our art as well as to greater perfection of it."
...Mont Reid

"I treated him... God healed him."
...Paré

"If you cut well and sew well your patient will get well."
...Deaver

MATERIALS AT HAND

The ideal suture should:

- Be strong enough to hold tissues in approximation
- Cause minimal interference with healing
- Incite minimal foreign body reaction
- Be easy to handle
- Be inexpensive

CATGUT

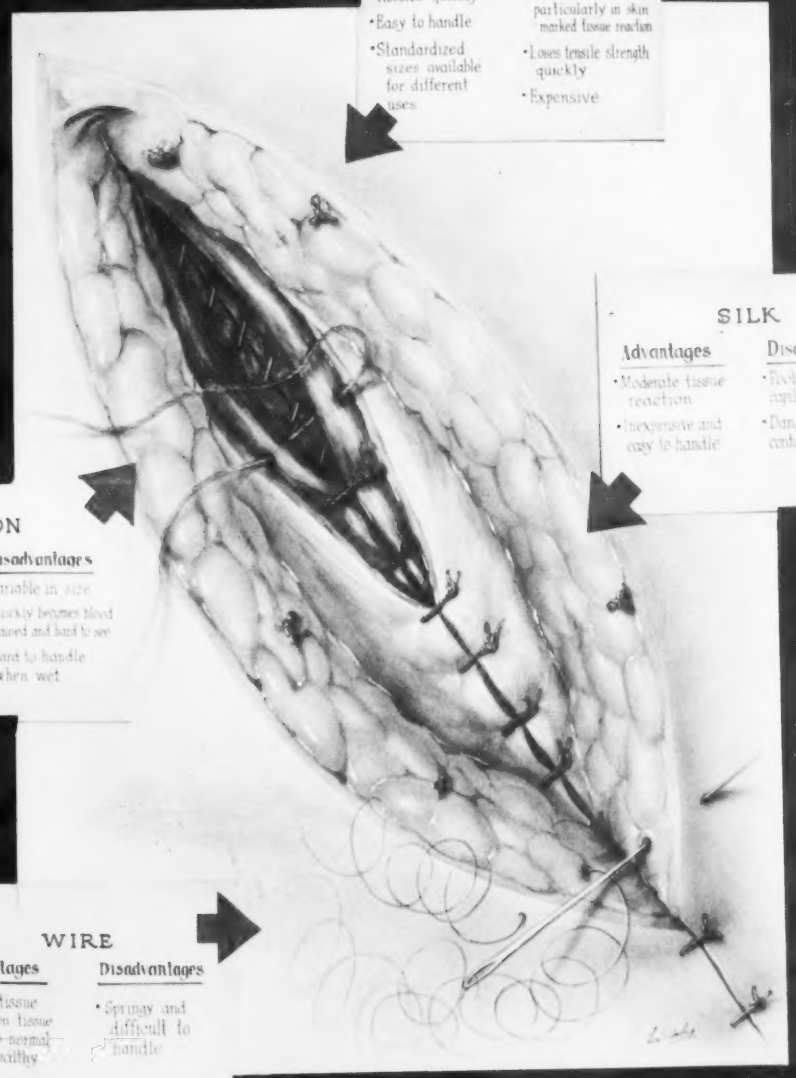
Advantages	Disadvantages
• Absorbs quickly	• Pools serum particularly in skin marked tissue reaction
• Easy to handle	• Loses tensile strength quickly
• Standardized sizes available for different uses	• Expensive

SILK

Advantages	Disadvantages
• Moderate tissue reaction	• Feels fluid by capillary attraction
• Inexpensive and easy to handle	• Dangerous in contaminated wounds

COTTON

Advantages	Disadvantages
• Little tissue reaction	• Variable in size
• Good tensile strength	• Quickly becomes blood stained and hard to see
	• Hard to handle when wet

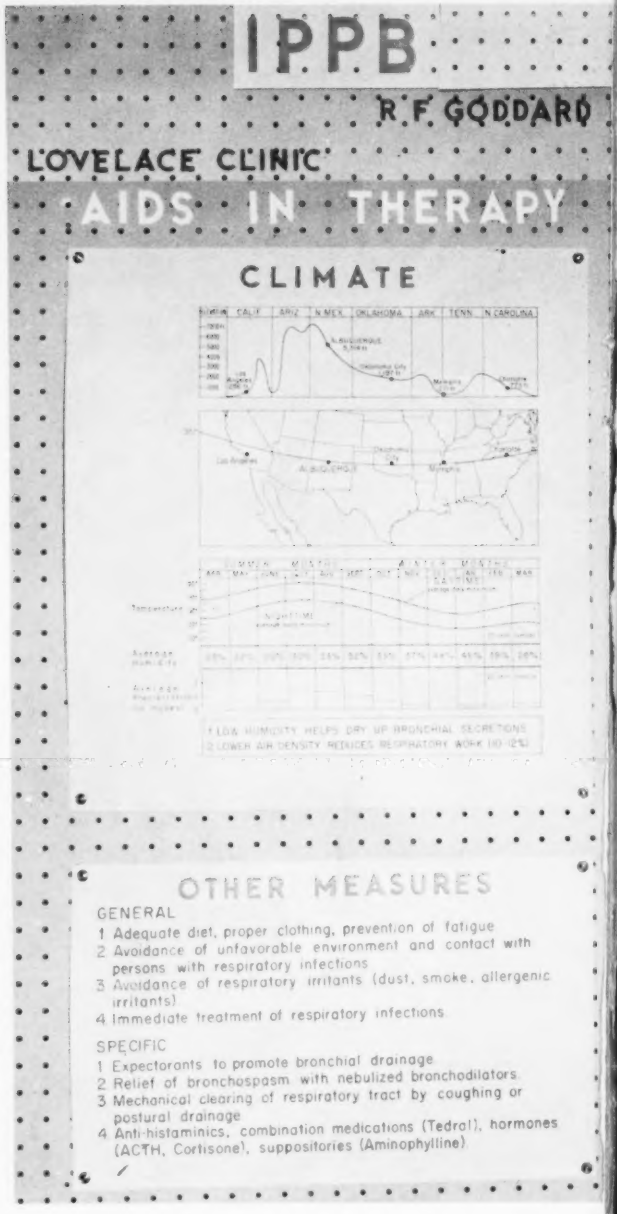


WIRE

Advantages	Disadvantages
• Little tissue reaction tissue remains normal and healthy	• Springy and difficult to handle

Above: Certificate of merit went to exhibit on "Morphology of the Heart Before and After Intracardiac Surgical Procedures," which showed the heart in full color transparencies, developed from roentgenograms. Elton Hoff, medical illustrator, and Conrad R. Lam, Henry Ford Hospital, Detroit, accept award from Dr. Hull.

Billings Bronze Medal, third-place award for excellence of correlating facts and excellence of presentation, is presented above by Dr. McMahon (r.) to C. J. Tupper, University of Michigan, Ann Arbor, for exhibit, "Periodic Health Appraisal: Method and Results of Examination." Co-exhibitors were Robert J. Bolt and O. T. Mallery, Jr.


IPPB
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LOVELACE CLINIC
AIDS IN THERAPY
CLIMATE
OTHER MEASURES
GENERAL
1 Adequate diet, proper clothing, prevention of fatigue
2 Avoidance of unfavorable environment and contact with persons with respiratory infections
3 Avoidance of respiratory irritants (dust, smoke, allergenic irritants)
4 Immediate treatment of respiratory infections
SPECIFIC
1 Expectorants to promote bronchial drainage
2 Relief of bronchospasm with nebulized bronchodilators
3 Mechanical clearing of respiratory tract by coughing or postural drainage
4 Anti-histaminics, combination medications (Tedral), hormones (ACTH, Cortisone), suppositories (Aminophylline)

Above: Results of the use of combined intermittent positive pressure-aerosol therapy in pediatrics were reported in exhibit by Roy F. Goddard, Ulrich C. Luft, and James Clark, Lovelace Clinic, Albuquerque, N. Mex.

At left: Hektoen Silver Medal, second-place award for original investigation, was given to exhibit on "Experimental Procedures for Inducing Acceptance of Tumor Homografts," by George D. Snell, Nathan Kaliss, and Andrew A. Kandutsch, R. B. Jackson Memorial Laboratory, Bar Harbor, Me. Dr. Kandutsch (r.) accepts award from Dr. Condon. Exhibit showed successful experimental methods used in mice to abrogate normal resistance to tumor homografts. Methods employ prior injection into the prospective host of suitable tissue preparations or antiserums to the tissues.

THERAPY IN PEDIATRICS

M.D. U.C. LUFT, M.D. & J. CLARK, P.E.
ALBUQUERQUE, NEW MEXICO

SUMMARY OF CASES

INFANTS & CHILDREN RECEIVING INTERMITTENT POSITIVE PRESSURE AEROSOL THERAPY

SEPTEMBER, 1952 to MAY, 1955

AGE GROUP	NUMBER TREATED	RANGE OF TREATMENTS	IMPROVED WITH THERAPY[1] NUMBER	IMPROVED WITH THERAPY[1] PERCENT	NUMBER RECEIVING OTHER Rx	NUMBER RECEIVING AEROSOL Rx
NEWBORNS[2]						
Premies	40		21	52.5		
Full Term	65		64	98.5		
Total	105		85	81		
Correction for extrapulmonary deaths			85/94	90		
INFANTS[3]	10	2-10	8	80	4	45
CHILDREN[4]	76		74	97	34	28
Asthma	40	12-75	38[5]	95	25	
Bronchiectasis and Bronchitis	7	10-50	7	100	3	
Chronic Cough	17	6-24	17	100		
Cystic Fibrosis of Pancreas	1	40	1	100		
Sinusitis	7	4-12	7	100	4	
Miscellaneous Respiratory Conditions[6]	4	1-10	4	100	2	

1. Survivals, in the case of newborns and infants.
2. Children treated only with aerosol for bronchiolitis, croup, etc.
3. IPPB resuscitation and treatments given via GBL Infant Hand Resuscitator.
4. Treatments given via Bennett Pressure Breathing Therapy Unit. Children ages 1-5 yrs. given treatments via modified Bennett Infant Therapy Unit.
5. Objective data was not available for one patient.
6. Vocal cord paralysis, croup, atelectasis, bleeding, etc.

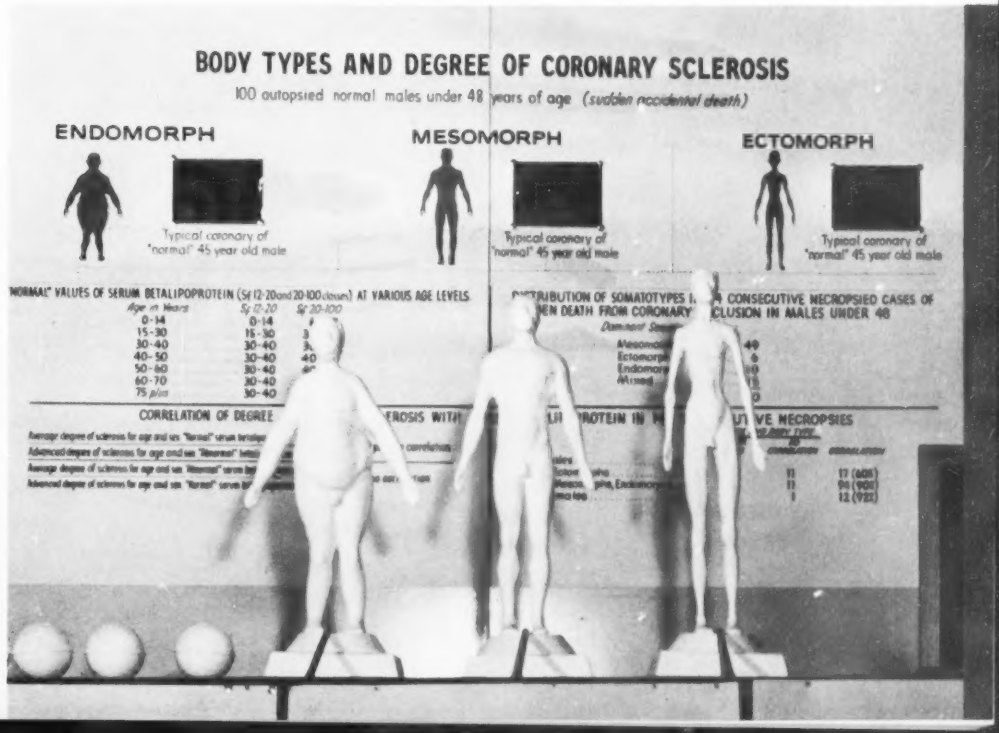
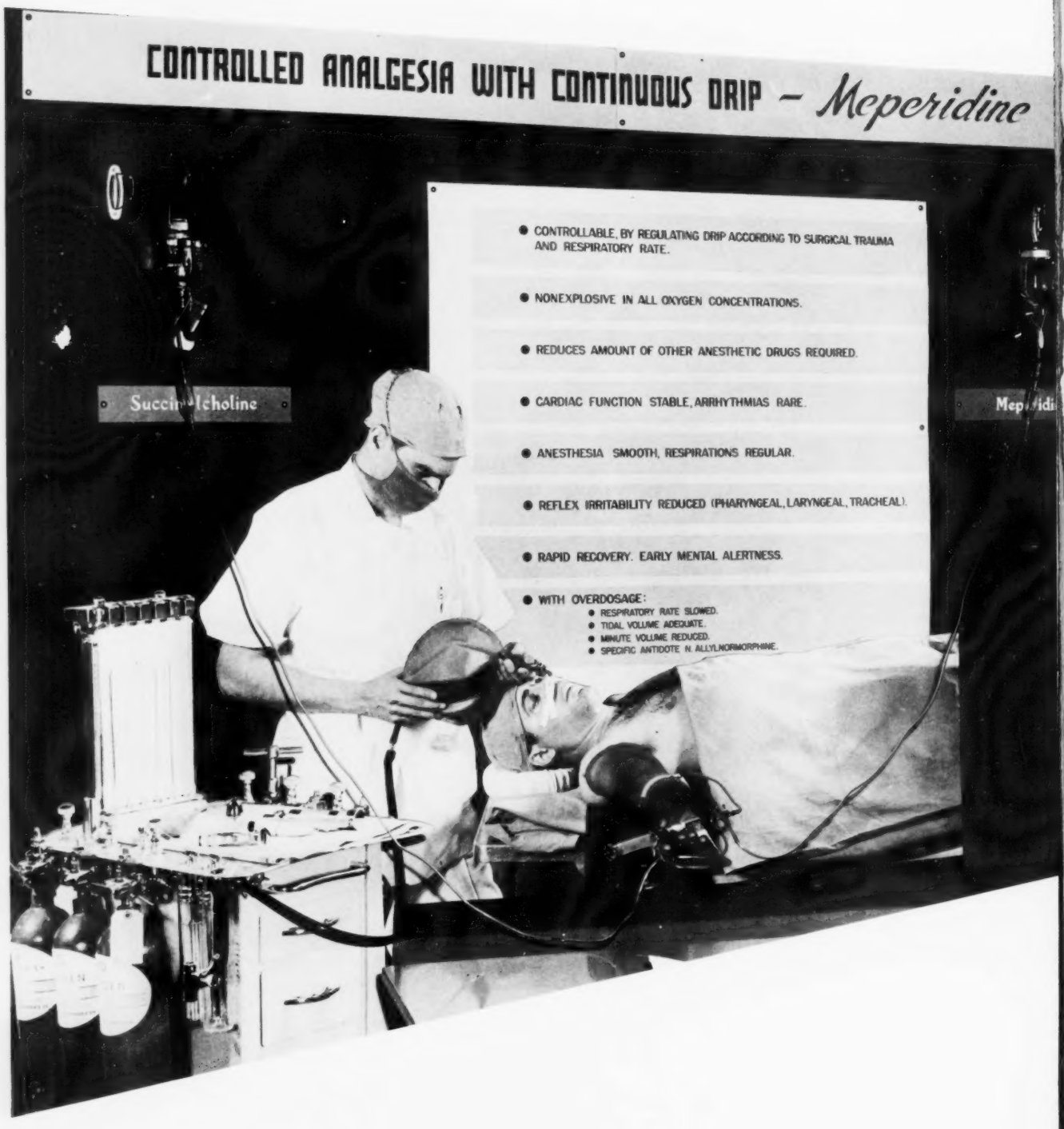

BODY TYPES AND DEGREE OF CORONARY SCLEROSIS
100 autopsied normal males under 48 years of age (sudden accidental death)
ENDOMORPH
MESOMORPH
ECTOMORPH
Typical coronary of "normal" 45 year old male
Typical coronary of "normal" 45 year old male
Typical coronary of "normal" 45 year old male

Exhibit on "Current Concepts in Atherosclerosis," by I. J. Greenblatt, T. D. Cohn, David Spain, and Leo Gitman, Beth-El Hospital, Brooklyn, N. Y., included models of three principal body types and information on degree of coronary sclerosis in each.


CONTROLLED ANALGESIA WITH CONTINUOUS DRIP – Meperidine
Succi lcholine
Mep idi
● CONTROLLABLE, BY REGULATING DRIP ACCORDING TO SURGICAL TRAUMA AND RESPIRATORY RATE.
● NONEXPLOSIVE IN ALL OXYGEN CONCENTRATIONS.
● REDUCES AMOUNT OF OTHER ANESTHETIC DRUGS REQUIRED.
● CARDIAC FUNCTION STABLE, ARRHYTHMIAS RARE.
● ANESTHESIA SMOOTH, RESPIRATIONS REGULAR.
● REFLEX IRRITABILITY REDUCED (PHARYNGEAL, LARYNGEAL, TRACHEAL).
● RAPID RECOVERY. EARLY MENTAL ALERTNESS.
● WITH OVERDOSAGE:
● RESPIRATORY RATE SLOWED.
● TIDAL VOLUME ADEQUATE.
● MINUTE VOLUME REDUCED.
● SPECIFIC ANTIDOTE N. ALLYLNORMORPHINE.

Experiences with the use of continuous drip meperidine in 1,000 cases were reported in exhibit by H. M. Ausherman, W. K. Nowill, and R. C. Martin, Duke Hospital, Durham, N. C. The drug was administered as a continuous or intermittent dilute drip in a concentration of 0.5 mg. per cc., usually in conjunction with Pentothal sodium and nitrous oxide. In the 800 receiving meperidine, 51 per cent less Pentothal sodium was utilized than in the 200 controls receiving only Pentothal sodium, nitrous oxide, and muscle relaxant when indicated.

SUMMARY

Properties of Meperidine

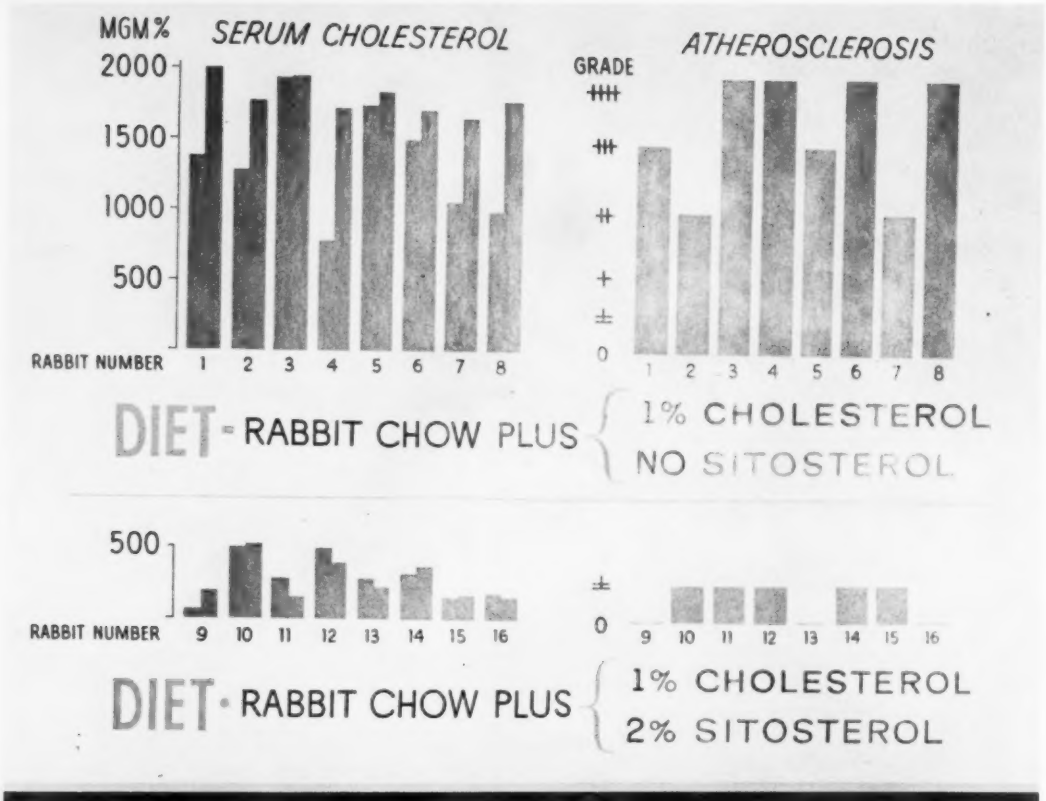
1. Potent analgesia with mild sedation.
2. Respiratory depression with large doses rapidly administered. Rate diminishes, tidal volume adequate. Depression reversible with N. Allylnormorphine.
3. Blood pressure, pulse rate stable with continuous dilute administration.
4. Rapid injection intravenously of concentrated solution may produce hypotension.
5. Cerebral blood flow enhanced.
6. Blocks vagal impulses to heart. Inhibits abnormal ventricular rhythms.
7. Pupillary size and reflexes not altered.
8. Rapid metabolism in liver.
9. Mild atropine-like action. Relaxes induced bronchial spasm.
10. Allergic urticarial manifestations about cannulated vein in 1% of patients. May release histamine from body tissues. Controlled with antihistamine drug intravenously.
11. Solutions stable in dilute or concentrated forms.

Method of Administration

1. Add 250 mg. Meperidine to 500 cc. bottle dextrose, 5%, in water or normal saline. Concentration is 0.5 mg. per cc.
2. If endotracheal intubation contemplated, topical anesthesia may be given : (a) transtracheally (b) spray (c) packs.
3. Dilute drip Meperidine, 30 to 40 drops per minute, may be started before anesthesia induced.
4. Unconsciousness and hypnosis produced with ultra-short acting barbiturate in 2 to 2.5 % solution.
5. When the patient is unconscious, nitrous oxide, 75 %, oxygen, 25 %, given from gas machine.
6. Short acting muscle relaxant administered to facilitate intubation.
7. During maintenance of anesthesia patient receives :
   (a) nitrous oxide, 75 %, oxygen 25 %, semi-open or non-rebreathing technique.
   (b) Meperidine drip regulated according to respiratory rate and surgical trauma.
   (c) muscle relaxant as indicated for surgery.
   (d) ultra-short acting barbiturate occasionally to maintain hypnosis.
   (e) assisted or controlled respirations when required to maintain adequate tidal exchange and minute volume.
8. Usually respiratory center remains functionally intact. When respiratory rate becomes less than 12 per min., assisted respirations indicated.

CONCLUSION

- MEPERIDINE CONFERS POTENT ANALGESIA DURING ANESTHESIA. IT REDUCES TOTAL AMOUNT OF PENTOTHAL SODIUM REQUIRED IN COMBINATION WITH NITROUS OXIDE-OXYGEN.
- CONTRIBUTES TO SMOOTHNESS OF ANESTHESIA.
- A VALUABLE ADDITION TO A GROUP OF NON-EXPLOSIVE DRUGS.
- DIMINISHES REFLEX IRRITABILITY.
- METABOLIZES RAPIDLY, ALLOWING EARLY AWAKENING.
- MINIMAL INTERFERENCE WITH CARDIAC FUNCTION.
- MAINTAINS RESPIRATORY CENTER FUNCTIONALLY INTACT, ALTHOUGH SLOWING RATE OF ACTION WITH HIGHER DOSAGES.
- N. ALLYLNORMORPHINE SPECIFIC EFFECTIVE ANTIDOTE TO RESPIRATORY DEPRESSION.
- IN 10 OF 800 PATIENTS, URTICARIAL REACTIONS NOTED ALONG COURSE OF VEIN THROUGH WHICH MEPERIDINE FLOWED.



Animal experiments showing effectiveness of Sitosterol in preventing hypercholesteremia and atherosclerosis in cholesterol fed rabbits.

Effect of oral administration of sitosterol on serum cholesterol concentration in rabbits was shown in exhibit by R. E. Shipley, Eli Lilly and Co., Indianapolis, which revealed that sitosterol, a plant sterol, appears to prevent intestinal absorption of cholesterol by a mechanism that involves formation of a mixed crystal with cholesterol.

Below: Billings Gold Medal was awarded to exhibit on "Esophagitis: a Common Condition Frequently Overlooked." Dr. Condon (l.) looks on as Dr. McMahon (r.) presents award to A. M. Olsen and H. W. Schmidt of Mayo Clinic and Mayo Foundation, Rochester, Minn. Co-exhibitors were F. H. Ellis, J. G. Grindley, and A. H. Bulbulian. Exhibit told of various conditions producing esophagitis, showed pathological specimens, and listed methods of treatment.

Below: Hektoen Gold Medal went to exhibit, "General Hypothermia in Surgery," from University of Colorado Medical Center, Denver, which gave analysis of use of hypothermia in surgery on more than 100 patients. Dr. Donovan C. Browne (l.), New Orleans, and Dr. McMahon (r.) make presentation to Arthur Prevedel and Emil Blair, who worked with Henry Swan, Sylvan Baer, Vernon Montgomery, and Strother Marshall as co-exhibitors.

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814. Vent-El-Aire
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820. Dried human fibrinogen
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822. Closed-circuit TV equipment
823. Addressograph for hospital paperwork
824. Compressor-aspirator
825. Floor machine and vacuum
826. Disposable chutes
827. Detergent aerosol
828. On-patient identification
829. Surgical dressings
830. Stretcher
831. Electrosurgical unit
832. Non-adherent strips
833. Oxygen therapy service
834. Snap-out forms
835. Pads and rolls
836. Seal-in-foil reagent
837. Suture packaging
839. Disposable blood lancet
840. Inform controls
841. Anniversary furniture
842. Pressure-compensated flowmeter
843. Bedside drainage container
844. Hospitality light
845. Photocopy equipment
846. Nurse call system
847. Recorded entertainment
848. Baumanometers
849. Drapery fabric
850. Needle cleaner
851. Airkem
852. Laundry equipment
853. Meals-On-Wheels
854. Hospital glassware washer
855. Controlled humidity
856. Generators
857. Hi-Tensile cabinets
875. Economy wheel stretcher
876. Paper-back autoclave tape
877. Machine dishwashing detergent
878. Portable television set
879. Institutional canned salmon
880. Increase worker's comfort
881. Electrically-conductive tile
882. Needle cleaner
883. Surgical cement
884. Examining and proctoscopic table
885. Sanitary breast shields
886. Information sign
887. Hypo sharpener
888. Coreco color camera
889. Light by touch
900. Contemporary lighting
901. Soap-detergent buying guide
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904. Surgical instruments
905. Tests in personnel selection
906. Decorating ideas
907. New tile booklet
908. Steamcraft cookers
909. Ceiling catalog

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803.	812.	821.	830.	840.	849.	875.	884.	903.
804.	813.	822.	831.	841.	850.	876.	885.	904.
805.	814.	823.	832.	842.	851.	877.	886.	905.
806.	815.	824.	833.	843.	852.	878.	887.	906.
807.	816.	825.	834.	844.	853.	879.	888.	907.
808.	817.	826.	835.	845.	854.	880.	889.	908.
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803.	812.	821.	830.	840.	849.	875.	884.	903.
804.	813.	822.	831.	841.	850.	876.	885.	904.
805.	814.	823.	832.	842.	851.	877.	886.	905.
806.	815.	824.	833.	843.	852.	878.	887.	906.
807.	816.	825.	834.	844.	853.	879.	888.	907.
808.	817.	826.	835.	845.	854.	880.	889.	908.
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This rail, with rotating action, is absolutely the easiest operating rail available. No slides to stick or bind—no sharp edges to damage wall or bed or cause injury to patient or personnel. One lock on each side—automatically locks when rail is raised. Can be lowered or raised with one hand in two seconds. No interference with orthopedic devices, bed side tables, footstools, or bed steps, even on high-low beds.

Rail Down in 2 Seconds For Access to Patient

In the down position rail is flush with bed spring—does not interfere with bedmaking. Rail can be removed or replaced on the bed in 10 seconds by releasing two spring catches on the cross member. Each set comes complete with cross members for mounting on bed. Easy method of mounting (four ¼" bolts through the bed frame). State make and model of bed when ordering.

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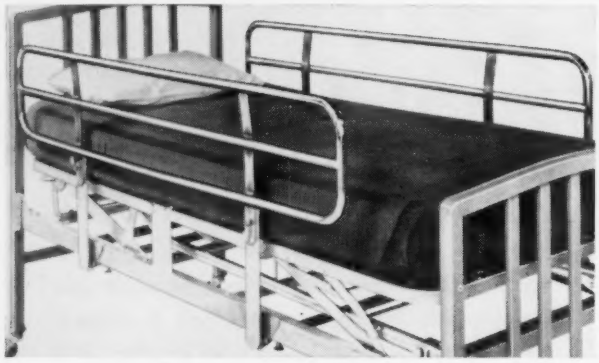
BUYER'S GUIDE

AHA
Product Preview

Many of the products that will be exhibited at the AHA convention in Atlantic City in September are pictured and described in this special Buyer's Guide section.

801. Bed side rails



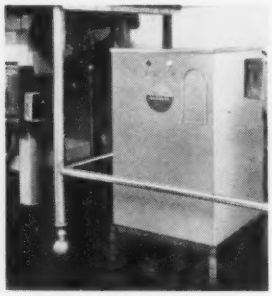
Rail has rotating action and no sharp edges to damage wall or bed. One lock on each side automatically locks when rail is raised. Rail can be lowered or raised with one hand in two seconds, manufacturer says. In down position rail is flush with bed spring—does not interfere with bed making. Pratt Hospital Equipment Mfg. Co. Booth 1049.

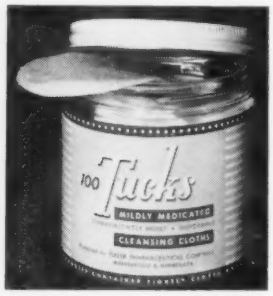
802. Wall washing machine

Wallmaster is designed to wash, rinse, and dry many types of interior wall surfaces. It revitalizes paint and restores original luster. A special cleaner and rinse water are applied to wall surfaces with large lightweight trowels, covered with heavyweight terry cloth pads. Cleaner and rinse are fed into trowels by fingertip control from pressure tanks. Machine uses no electricity. Quaker Maintenance Co. Inc. Booth 753.

803. Conductive terrazzo flooring

Portland cement flooring is laid without dividing it into strips. This freedom from joints in which germs and dirt can lodge makes it particularly acceptable for operating room use. Flooring is more comfortable for feet of operating room personnel. Booth 1014. Federal Flooring Corp.





804. Dishwashing aid

Rinsemaster electronic control unit and Zerospot, a rinse additive, will be exhibited at the Diversey Corp. booth. Rinsemaster automatically injects proper amount of Zerospot into rinse tank of dishwashing machine. Unit fits under rack tables of dishwashing machines. Booth 476.

805. Ready-to-use dressing

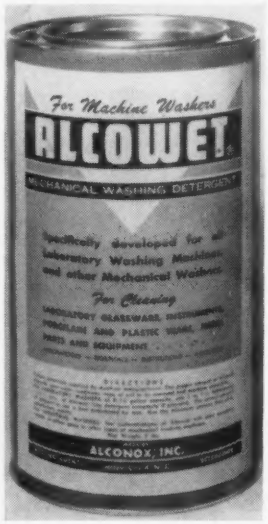
Tucks, 3" discs of cotton flannel saturated with witch hazel and glycerin, will be shown at the Baby Development Clinic. Tucks soothe patients, free nurses from making messy witch hazel packs. Can be used for episiotomies, hemorrhoids, and anorectal surgery. Booth 336.

806. Hospital size Baby Magic

Mennen Baby Magic, a non-greasy emulsion of cholesterol and related sterols plus lanolin, is absorbed by infant's skin with minimal rubbing. Baby Magic soothes and helps heal excoriated buttocks and chafed areas in the neck folds, elbow and wrist bends, and diaper area. The Mennen Co.

807. Detergent

Featured at the Alconox booth in Atlantic City will be various uses for Alconox, the hospital detergent for soak or hand washing operations. Alcowet for use in laboratory washing machines will also be displayed. Samples, literature, and information of interest to laboratory, operating room, nursery, blood bank, and central supply will be available. Booth 850.



So that you can locate the products in the exhibition hall, we have included numbers of the booths in which they will appear. If you desire further information on any of the products, please check the Buyer's Guide number on the reply card facing page 41.

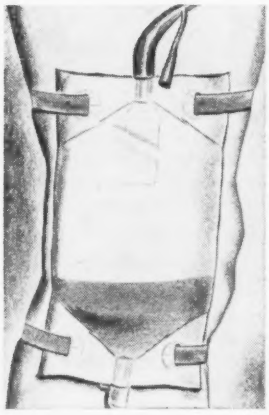
808. Drug for daytime tension

Nodular Roche, a new drug especially useful for daytime tension and nervous insomnia, is not a barbiturate, but a piperidine derivative. Clinical studies in more than 3,000 patients have shown that Nodular is a mild sedative-hypnotic, exceptionally well tolerated. Hoffman-La Roche, Inc. Booth 505.

809. Sterile polyethylene tubing

Displayed at the Clay-Adams booth will be sterile tubing ready for instant use right from the package. Also on display will be the Adams Sero-Fuge, designed expressly for blood bank use. Further items will be the Adams thermometer shaker, centrifuges, CRI germicide, autoclip, blood-testing equipment, variable speed rotators, anatomical and skeletal models. Booth 367.

810. Urine bag

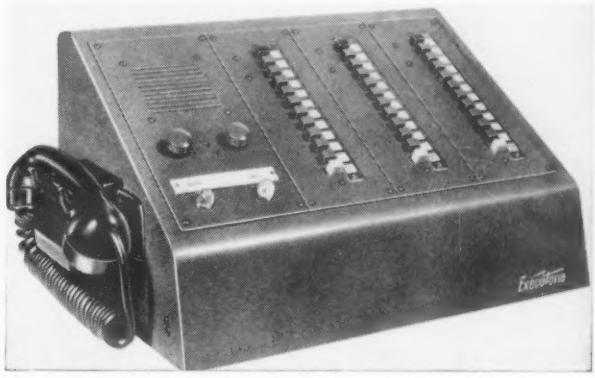


Dispoz-A-Bag eliminates needs for inconvenient jugs or bottles that have to be cleaned and deodorized. Bag, made of lightweight plastic that will not absorb urine or odor, is designed for use of hospital patient with indwelling catheter. Can be attached to the leg by adjustable rubber straps. Flutter valve in bag prevents return flow even when patient is sitting or reclining. Each bag is individually packaged, and is sterile, ready for use. C. R. Bard, Inc.

811. *Instrument for electrical resistance*

Conductometer is designed for testing the electrical resistance of personnel, flooring, and equipment in hospital operating rooms. Exclusive elbow switch permits personnel testing under aseptic conditions. Two separate circuits—one of 90 volts, used to test personnel without danger of shock, and the other of 500 volts, for testing flooring and equipment. Conductometer guards against static spark explosions in operating rooms. Booth 1016. Conductive Hospital Accessories Corp.

812. Audio-visual call system



Electronic nurse call system which permits the nurse to identify a patient's call from many points on the nursing floor will be exhibited by Executone, Inc. System, which makes provision for nurse control stations at different locations on floor can transmit the whispering or weak breathing of very ill patients. Also featured will be a newly developed type of corridor signaling lamp and an explosion-proof patient's bedside call button for use in oxygen tents. Booth 556.

813. Technical close-up camera

An inexpensive, easy-to-use technical close-up outfit, particularly suited to medical photography, will be featured at the Eastman Kodak exhibit. The unit is designed for use by inexperienced photographers who want to produce color transparencies of maximum quality with a minimum of difficulty. Nurses, doctors, and hospital technicians with no photographic training can learn to use the equipment in a matter of minutes, manufacturer says. Booth 612.

BUYER'S GUIDE

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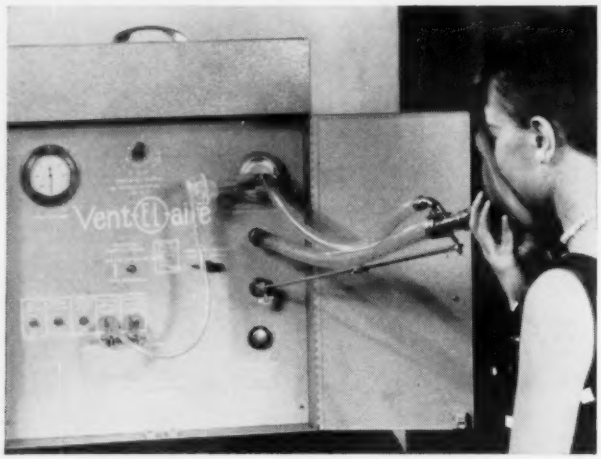
AHA Product Preview

814. Pressure breathing equipment

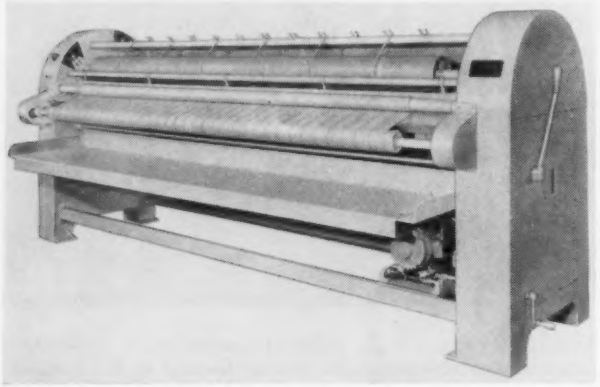


The Vent-El-Aire will be introduced by Eliot Medical Plastics, Inc. Multi-purpose unit is used in a variety of pulmonary disorders, depending upon which individual or multi-function is required. Intermittent positive pressure breathing on inspiration for bronchospastic disorders, such as bronchial asthma, and pulmonary emphysema; exsufflations with a rapid negative pressure as a cough machine for removal of bronchopulmonary secretions, in the treatment of poliomyelitis, atelectasis, and bronchiectasis. Resuscitation by means of controlled positive pressure on inspiration, with passive or negative pressure on expiration. Booth 267.

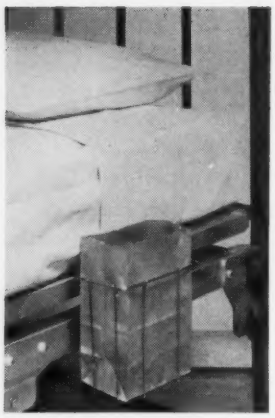
815. Prepackaged dressings

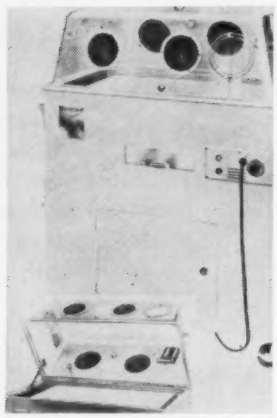
Prepackaged dressings to reduce labor costs are being shown at the Johnson & Johnson booth. The complete surgical dressing service is available without charge. Questions are invited on the topic, "How can the costs of surgical dressings be reduced without reducing the quality of patient care?" Booth 514.

816. Industrial ironer



Ironer is designed particularly for small and medium-sized hospitals. No high pressure steam boiler required. Also exhibited will be end-loading washer with stainless steel drain slide and self-balancing extractor, which reduces labor in transferring linens from washer to extractor. Chicago Dryer Co.





817. Paper bag holder

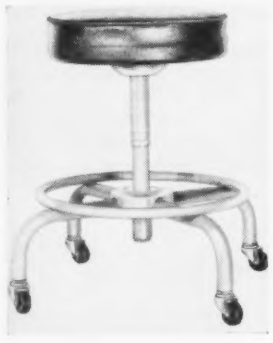
Holder hooks on hospital bed spring. With weight of mattress on it, it will make itself part of the bed. Made of heavy gauge wire, with plated hospital finish. Hospital Accessories Co.

818. *Oxygen therapy equipment*

Complete line of oxygen therapy equipment and accessories, from the Infantair model 1500M baby incubator, facilitating the latest technics in infant care, through a varied line of smaller equipment to the latest model 4000M Continentalair iceless oxygen tent. In addition, Plasticon and Fabrisheen sheeting will be on display, and full information on complete hospital supplies will be available. Continental Hospital Service, Inc. Booth 465.

819. Disposable enema unit

A complete ready-to-use disposable enema unit will be featured at the Pharmaseal booth. It has a soft smooth 5" plastic tip; four ounces of hypertonic sodium phosphate solution in bag for easy complete lower bowel evacuation. Manufacturer says it is fully effective in preoperative preparation, postoperative cleansing, impactions, and general routine use. Pharmaseal Labs.



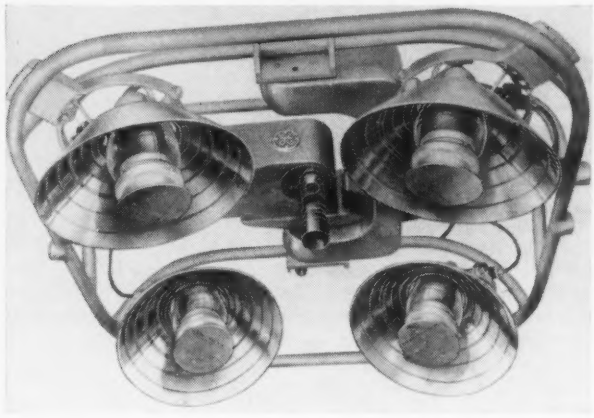
820. Dried human fibrinogen

Parenogen is dried human fibrinogen which, after reconstitution, may be injected intravenously into patients with dangerously low blood fibrinogen levels. Package contains one-gram bottle of dried parenogen, 50 cc. Ambot of distilled water, double-ended reconstitution needle, airway needle. Cutter Laboratories. Booth 606.

821. Laboratory stool

Featured will be the Ajustrite laboratory stool that has an adjustment range—with the upholstered seat—of from 17" to 25". Seat cushion is filled with curled hair and foam rubber, and covered with U.S. Naugahyde. All metal parts are chrome-plated in satin finish. Adjusto Equipment Co.

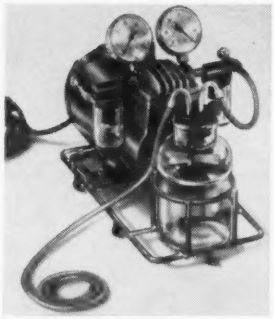
822. Closed circuit TV equipment

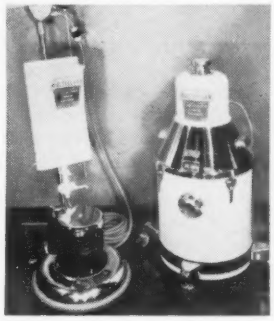


Closed circuit television equipment can be used for autopsy, dermatology, fluoroscopy, microscopy, obstetrics, surgery, and x-ray. High quality image, with excellent color definition. Small TV camera is adaptable to tiny quarters. High degree of flexibility; remote control, interchangeable lenses. Pictured above is a remote-controlled color camera mounted in a lighting fixture. General Electric Co. Booth 725.

823. Addressograph for hospital paperwork

Addressograph provides a repetitive writing system for many phases of hospital paperwork, with complete methods and mechanical service available locally. Highlighted will be a new outpatient identification system featuring a self-writing identification plate. Another feature will be a multigraph duplicator multilith model 81 that will demonstrate admitting information on multilith duplicating masters which produce form and admitting information simultaneously. Booth 235. Addressograph-Multigraph Corp.





824. *Compressor-aspirator*

Air-Shields, Inc., will display a new compressor-aspirator. Pump provides oil-free, filtered air at controlled pressures up to 30 pounds, as well as controlled suction at negative pressures up to 20" of mercury. It is quiet-running, and equipped with a convenient carrying handle. Standard model 115 volt, 60 cycle AC. Booth 509.

825. Floor machine and vacuum

Featured at the Multi-Clean booth will be a silent operating team for hospital floor care. The floor-scrubbing and polishing machine, and heavy-duty, wet-dry vacuum cleaner, especially engineered for unusually quiet operation, are finished in chrome and hospital-white enamel. Booth 765.

826. Disposable chutes

Wilkinson Chutes, Inc., will display soiled linen, rubbish, diaper, tin can, and dust chutes for centralized disposal of waste materials. Featured will be the hopper type, noiseless, self-closing, stainless steel intake doors. Dust chutes for dry-mop cleaning in a self-operating unit will also be displayed. Booth 1018.

827. Detergent aerosol

Alevaire, the detergent aerosol, is used to liquefy thick pulmonary accumulations of viscid exudates. It prevents respiratory difficulties due to bronchial obstruction, and maintains a free airway. Representative equipment pieces will be on display to demonstrate the administration of Alevaire to various types of patients. Winthrop-Stearns, Inc.

828. On-patient identification

Ident-A-Band, the on-the-patient band that helps prevent mix-ups in the hospital, will be featured at the Franklin C. Hollister Co. booth. Invaluable for checking identity before surgery (as pictured), before administering blood, and at medication time. Booth 667.

829. Surgical dressings

New and advanced studies in surgical dressings tailored for central supply in pre-packed form will be shown by the Marsales Co., Inc., along with machine-made dressings such as stick, cherry, intestinal, and appendix sponges, as well as mastoid and spinal fusion dressings, will be displayed. Booth 1007.

BUYER'S GUIDE

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AHA Product Preview

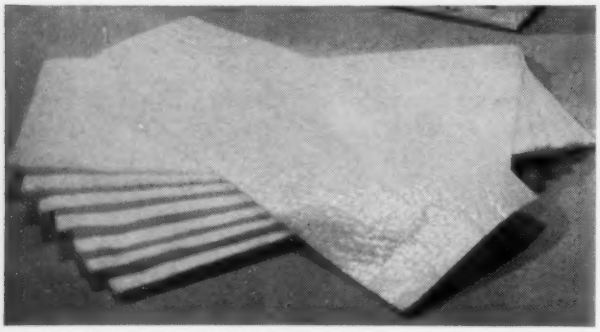
830. Stretcher

Stretcher for postanesthesia rooms, over-bed transfer, labor and emergency rooms will be featured at the Shampaine Co. booth. The Trans-All features single-end control allowing for complete operation of unit, transport and transfer of patient by a single attendant. Other features of the unit are: lateral tilt to either side, positive height adjustment, Trendelenberg and reverse Trendelenberg. Stretcher is furnished in two models, polished stainless steel and silverlux finish. Trans-All eliminates lifting and excessive handling of patients—in some cases bypasses the need for intermediate transfer to recovery or labor-room beds.

831. Electrosurgical unit

Featured will be the Stryker electrosurgical unit—a combination of unusual and economical power surgical tools. It includes a bone saw, drill, screw driver, rotary burr, dermatone, and facial abrasive sander. Child's suspension traction frame and new aluminum Stryker turning frame will also be displayed. Booth 872. Orthopedic Frame Co.

832. Non-adherent strips



Telfa strips, pictured above, were introduced at the 1954 AHA convention in Chicago. Now an entire new group of Telfa dressing units is available for care of the simplest and the most extensive wounds—dressings that keep the wound dry without adhering to healing tissue. Bauer & Black Co. Booth 820.

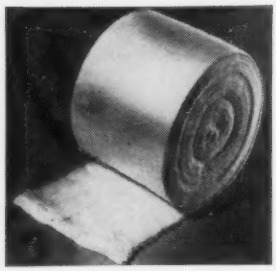
833. Oxygen therapy service

Complete hospital therapy oxygen service of Ohio Chemical & Surgical Equipment Co. will be featured. In addition, there will be the infant circle absorber, the vacuum regulator, vacuum pump, improved aerosol therapy apparatus, model 25 oxygen tent, Tenso-Pli sutures and redesigned needles, Stille instruments, medical gases, and other anesthetic agents. Booth 643.

834. Snap-out forms

Multiple-copy snap-out forms, with special type of pressure-sensitive adhesive at upper edge of original copy. Adhesive enables one to affix slips to lab report form by pressure. In addition to this lab slip, Physicians' Record Co. will show the latest medical record forms. Booth 371.

835. Pads and rolls



They combine a highly absorbent long-fiber cotton with a nonabsorbent cotton which serves as impervious backing. Also available all-absorbent. Pads and rolls are efficient for softness and cleanliness. Acme Cotton Products, Inc.

836. Reagent tablets

Clinitest, sealed-in-foil reagent tablets, will be featured at the Ames Co., Inc., booth. Tablets, for urine-sugar testing, are recommended by doctors because the last tablet is as accurate as the first. Hermetically sealed tablets can't be harmed by moisture, humid weather, or careless handling. Also displayed will be Ictotest, new specific and sensitive diagnostic tablet test for detection of urine bilirubin as an aid to dignosis and management of jaundice and hepatitis. Booth 434.

837. Suture packaging

Latest in suture packaging will be shown at the Davis & Geck booth. Pictured above is Measuroll, dispensing package that permits a nurse to cut 20 strands of Anacap silk and surgical cotton and 10 strands of Surgaloy stainless steel sutures of any desired length with one snip of the scissors. Surgilope, sterile pack of Anacap silk and surgical cotton sutures, also to be exhibited, stores in one-third the space needed for jars and cans. Booth 662.

839. Disposable blood lancet

Sera-Sharp, the disposable blood lancet (pictured at left), will be shown at the Propper Mfg. Co. booth. The lancet with its shaped and serrated handle provides a firm finger grip. Polyplane point is sharp and less traumatic. Blood channel on the point increases strength. It is packaged for most convenient hospital use, with a hanging tab so that box can be placed on wall. Other items to be shown will be the Steri-card, the improved sterilizer control card for use in pressure autoclaves, and the Manuell Aneroid sphygmomanometer shown. Entire manipulation of the instrument may be done by one hand with the dial out of patient's line of vision. Booth 1044.

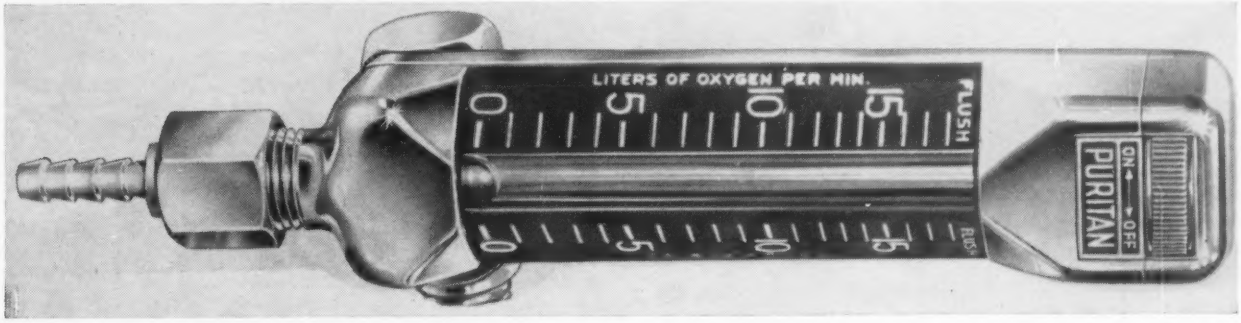
840. *Inform controls*

Inform controls are especially important in the summer months as an aid in control of infant diarrhea. Controls tell how efficient terminal procedure is—a way of making sure formula is meeting required condition. Smith and Underwood. Booth 209.

841. Anniversary furniture

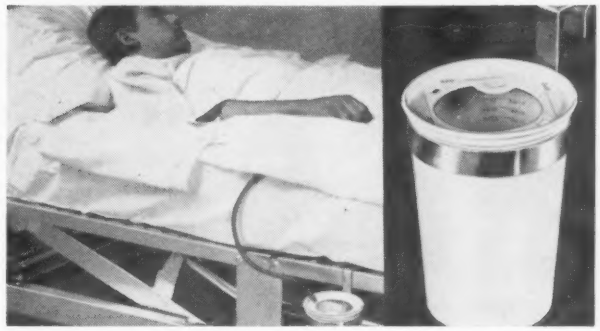
Featured at the American Hospital Supply Corp. booth will be the Tomac anniversary furniture in new Laurent finish. This furniture is custom-built from black cherry and is available in cherry durabake finish or greyed cherry finish. Furniture is pictured above. Tomac telescopic safety slides that fit all standard beds will also be shown. These slides, when not in use, telescope and fold up out of the way. Booth 530.

842. Pressure-compensated flowmeter



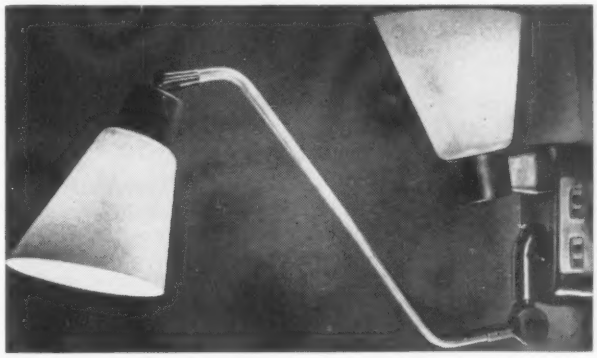
Provides accurate flow readings unaffected by back pressure, regardless of type of equipment being used with it. It may be purchased with the correct fitting for any oxygen piping system, or as an integral part of regulators for cylinder use. Flowmeter is constructed of chrome-plated metal in natural handle-grip design. Desired flow rate is set by touch of the thumb to the on-off control, and no further adjustment is necessary even during protracted administration. Puritan Compressed Gas Corp. Booth 925.

843. Bedside drainage container



Kenwood Dran'r eliminates need for carrying, washing, and sterilizing heavy glass bottles or jars. It can be used once and discarded. Specially treated cup will hold drainage for a minimum of 24 hours—is graduated on the inside in ounces and cc. Separate lid is provided with plastic window so that contents are always visible. Lid has two rectangular tubing holes to accommodate disposable tubing, and is printed with space for name, room number, and bed. Will Ross Inc. Booth 430.

844. Hospitality light



Manufacturer says that hospitality lights cut costs up to $1.50 per room. Single unit performs up to five electrical functions—includes reading light, night light, indirect light, and two convenience outlets. Swivel actions permit fingertip adjustment of reading arm to any angle. Switching combinations are many. Kurt Versen Co.

845. Photocopy equipment

Sensi-Trol 56, the newly developed equalizing ingredient, alleged to scientifically balance and control variances in light, temperature, and operating conditions, to make copying easier with any type photocopy equipment, will be shown by American Photocopy Equipment Co.

BUYER'S GUIDE

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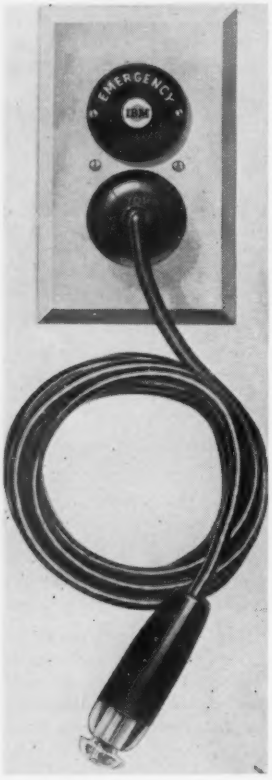
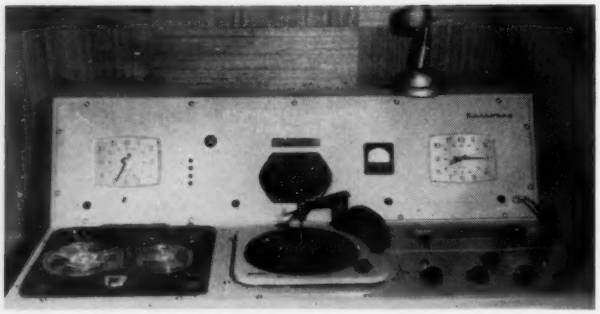
AHA Product Preview

846. Nurse call system



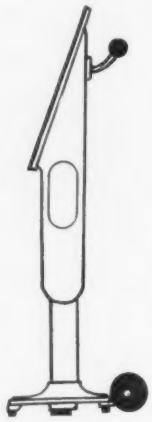
The IBM nurses' call system enables hospital patients to summon nurses by means of a bedside call button. When pressed, button transmits audible and visible signals to corridor lights and nurses' stations in various sections of hospital. On release, button plunger returns to halfway position, allowing the visible lamp signals to remain and stays locked in that position until reset by nurse. Luminous material causes call button to glow—enables patient to locate it easily in the dark. Special call stations are available for use in operating rooms, kitchens, exposed locations. Also featured will be IBM nurse-to-patient communication system which enables a nurse to ascertain a patient's needs before visiting the room, and to check patients to determine whether they are breathing normally. International Business Machines Corp.

847. *Recorded entertainment*



Featured at the AHA convention will be station "WELL," new Dahlberg Co. apparatus which makes it possible, from one central point, to prepare and disseminate throughout the hospital any kind of recorded or live entertainment program. Broadcaster consists of: tape recorder, record player, and FM/AM radio and microphone built into one unit, with control panels which enable hospital to transmit programs to each patient without any wiring. Hospital can select any type of program or put on a live show with local talent. It is possible to transmit all programs over existing paging systems. Booth 929.

848. Baumanometers



Representatives of the W. A. Baum Co., Inc., will be on hand to discuss standardization of equipment—particularly as applied to blood pressure equipment. Baumanometers especially suited to hospital needs will be shown. Booth 874.

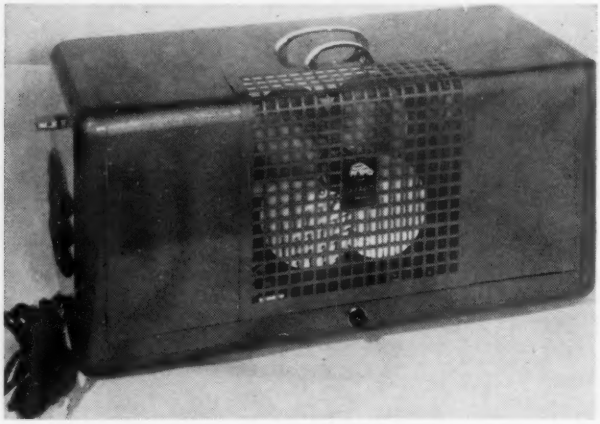
849. Drapery fabric

Featured at the Haag Brothers booth will be a vat-dyed, preshrunk, water-repellent hospital slipcover fabric. It is crush, puncture, and stain-resistant. Material is prelaundered. Booth 333.

850. Needle cleaner

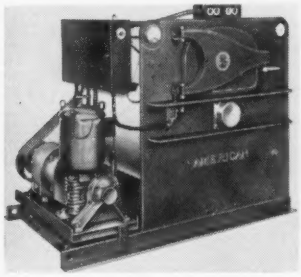
Macalaster Bicknell Parenteral Corp. will display their Kleen-O-Matic needle cleaner at the AHA convention. This new unit washes and rinses 700-1,200 needles per hour. The entire processing is automatically regulated by a timer which re-cycles itself if cycle is ever interrupted—then shuts itself off at the end of the cycle. Detergent is dispensed into wash water by automatic detergent dispenser. After rinsing, clean needles are emptied onto an inspection tray before autoclaving.

851. Airkem



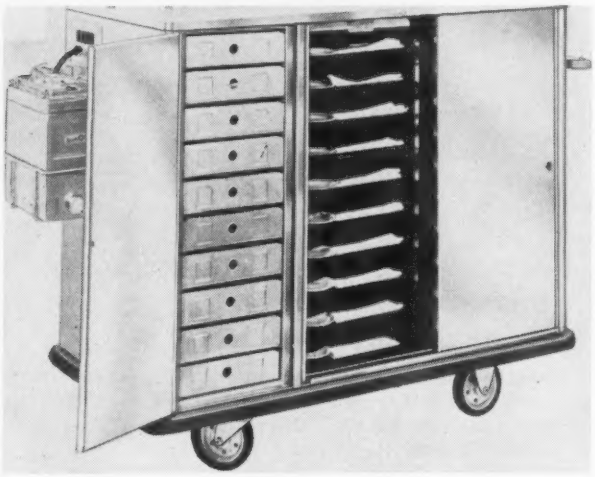
Airkem Osemeran model designed to dispense Airkem liquids in non-air-conditioned areas. Ideally suited for the counteraction of odors where inconstancy and malodors create a ward problem. Each unit holds total of 8 pint bottles of liquid; will control odors in areas up to 1,000 square feet. Booth 961.

852. Washer-extractor



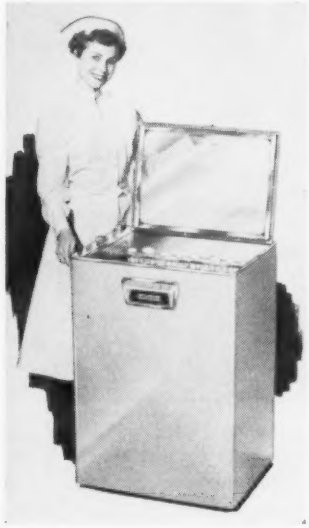
Cascadex laundry washer-extractor has a capacity of 100 pounds. It is 40x30", and has been designed to save original equipment investment, floor space and labor by combining washing and extracting of laundry work into one compact unit. The Cascadex is a companion to the 50 pound 32x24" capacity machine. American Laundry Machinery Co. Booth 673.

853. Meals-On-Wheels



This M-20 unit is constructed of heavy duty stainless steel, has two cold tray compartments with double panel insulated sliding doors and built-in oven with temperature selection. Individual control operates two beverage containers. This model eliminates need for floor kitchens, duplicate personnel, and mealtime noise and confusion on patient floors. Crimsco, Inc. Booth 271.

854. *Hospital glassware washer*



Completely automatic laboratory and hospital glassware washer will be displayed at the James, Inc. booth. It features new enlarged wall of-water washer action—scrubs every surface with twisting pressure. Deflector vane directs water under pressure into each vessel at the proper angle. Unit is constructed of stainless steel; recirculates 57 gallons of water per minute at full load. Slipping clutch prevents jamming. Booth 276.

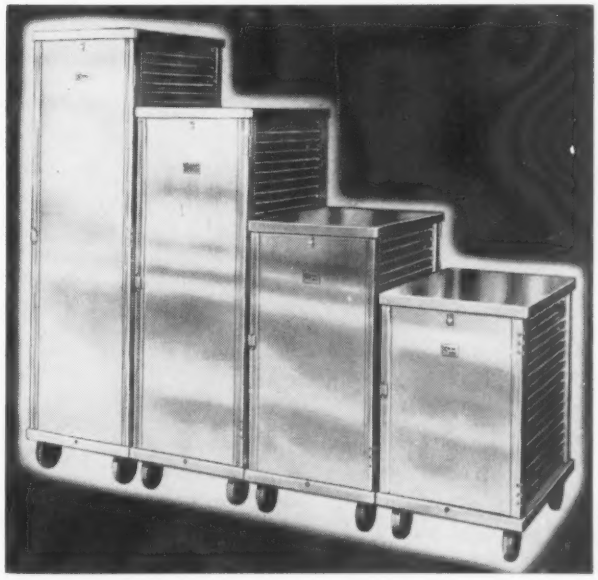
855. Controlled humidity room

Melco natural fog general demonstration will be featured at the Melco booth. Unit can convert any hospital room into a high humidity or croup room. It permits doctor to prescribe temperatures between 68 to 85°. Patient receives full therapeutic benefits of supersaturated humidity without extreme temperature, and without precipitation. In addition, 40 percent oxygen limiting devices which attach directly to incubators, oxygen station outlets, and a complete line of oxygen therapy equipment will be featured.

856. Generators

Two new types of generators specifically designed to relieve personnel problems in x-ray departments will be exhibited at the Picker X-Ray Corp. booth. Generators can be operated with no more skill than is needed to use an automobile radio. Picker representatives will demonstrate how they can improve productivity, even with untrained personnel. Booth 652.

857. Hi-tensile cabinets

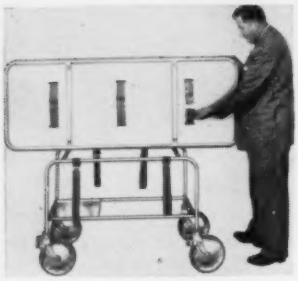


Included in the Crescent Metal Products booth will be the entire line of Hi-Tensile cabinets. The new 36" undercounter utility cabinet will be featured—it can be used as a storage and bussing cabinet. All of the equipment is made of light-weight aluminum, and is mounted on noiseless neoprene rubber casters which make it good for hospital work. Crescent stresses complete sanitation which is inherent in aluminum. There is no possibility of corrosion or transfer of food tastes or odors—is nontoxic and will not harbor bacteria. Booth number 956.

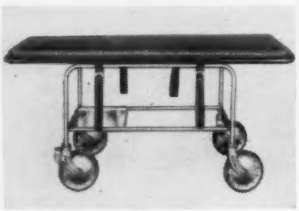
BUYER'S GUIDE

Continued

875. Economy wheel stretcher



This model 100 wheel stretcher is a full 26¾" by 74". It is slotted for holding straps to prevent pad slide. Litter top is locked on and can be removed in one minute. Litter top is surrounded by heavy-duty rubber bumper. Stretcher is built up with tubular construction in silver luster finish or stainless steel. Aluminum blanket shelf is important part of lower box frame. Casters are full 10" size. Hausted Manufacturing Co.



876. Paper-back autoclave tape

Flat backing of this tape offers an additional advantage over standard crepe-backed tapes because it has a smooth writing surface. Some hospitals write contents and date on the tape instead of the wrap, making laundering of the wrap easier. Available in widths up to 3". Behr-Manning Division of Norton Co.

877. Machine dishwashing detergent

Oakite DCM is a new machine dishwashing detergent which eliminates spotting of dishes and prevents lime buildup on the machine. It is particularly effective in hard water areas. Dishes dry fast and bright, according to the manufacturers. The material is claimed to be effective in concentrations as low as ⅛ ounce to the gallon, and to be non-toxic, requiring no special handling. Oakite Products Inc.

878. Portable television set

Light-weight set is suited for viewing in hospital rooms. Recommended for use in primary reception areas. Set weighs 32 pounds, has a 14" picture. General Electric.

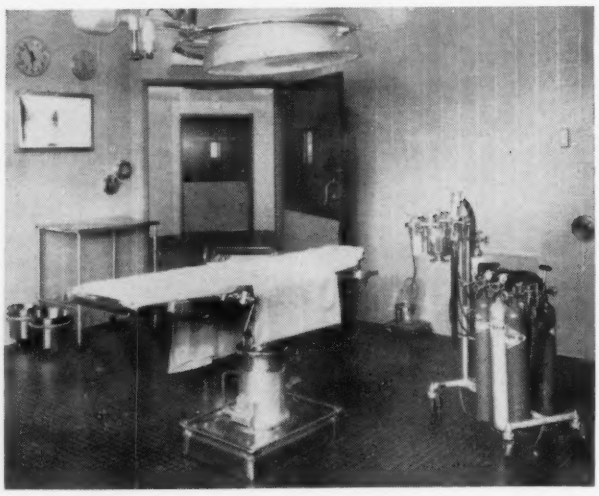
879. *Institutional canned salmon*

Salmon is hand-packed in four-pound tins, with 12 tins to the case. Each can holds approximately one entire salmon. It is available in several grades—Sockeye, Cohoe, pink, and chum. G. P. Halferty & Co.

880. Increase worker's comfort in hot weather

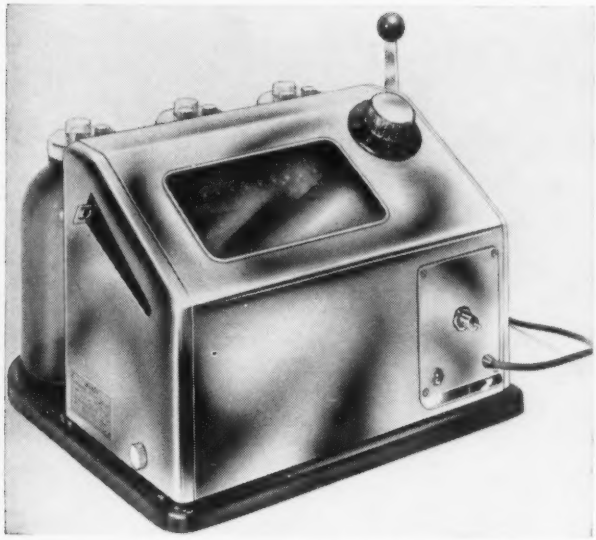
Ace salt dispenser offers dependable service in institutions. It holds 750 10-grain salt tablets. Made of 95 percent glass and plastic; strong, simple, foolproof. General Scientific Equipment Co.

881. Electrically-conductive tile



This ceramic tile is unglazed, dust-pressed, square-edged. It was developed specifically to reduce the danger of anesthesia explosions resulting from electrostatic hazards in surgical suites, the manufacturer says. Mosaic Tile Co.

882. Needle cleaner



Features: electrically driven shaft for power swabbing of needle hubs and triple-sequence flushing by three separate cleaning fluids forced through each needle under 25 pounds of pressure. This is followed by forced air drying. Tests show a minimum of 80 percent time saved over hand methods. American Sterilizer Co.

883. *Surgical cement*

Cement can be used for sealing Seep-Pruf rubber body adapter to the body, and for colostomy, ileostomy, and other postoperative appliances. It contains liquid latex, N-hexane, zinc oxide, and mineral oil. Graham-Field.

884. Examining and proctoscopic table

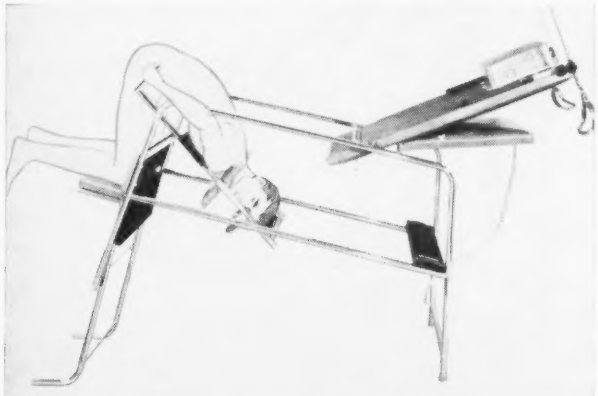
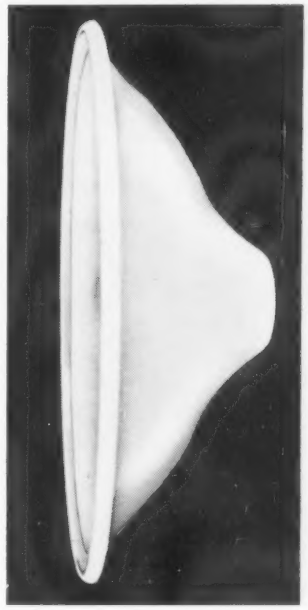


Table has cradle for sigmoidoscopy and anorectal examinations. Position pictured makes it impossible for patient to move away. While patient is securely supported, no pressure is exerted against the abdomen. This prevents compression of the lower bowel. Eder Instrument Co.

885. Sanitary breast shields

Plastishields are lightweight breast shields fabricated from nylon. Used in prenatal and postpartum home and hospital care, they may be sterilized by boiling or autoclaving. Smooth inner surface protects lactating nipples from dryness and external irritation. Manufacturer says it minimizes incidence of sore, cracked and fissured nipples. Mild suction assists in the correction of flat or partially inverted nipples. Arrow-Head Plastics, Inc.



886. Information sign

Sign allows ready insert of a name protected by a heavy vinyl window and held in place by spring tension. Printed copy can be made by the photo composing machine which prints on strips of paper 1⅜" wide. Comes in 7" and 10" lengths, for desk or door. Desk-Sign Co.

of Clean Hypodermic Needles
with the Knight **AUTOMATIC HYPODERMIC NEEDLE CLEANER**

Can Clean as Many as 2400 Needles in an Hour
Entirely Automatic Cleaning Processes
Preserve and Protect Needles
A Compact, Rugged, Easy-to-Operate Unit
Powered by Controlled Air Pressure
Makes Impressive Cut in Needle Cleaning Costs

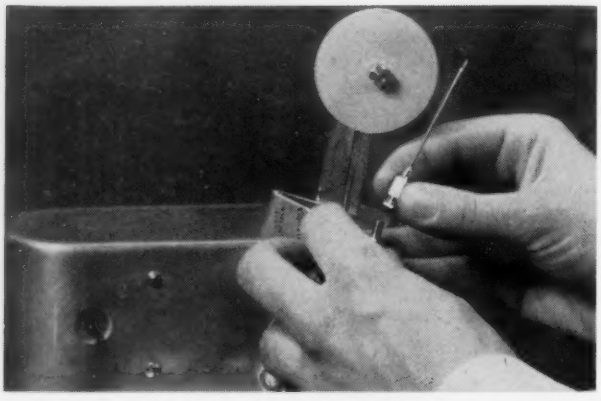
Write for literature

TECHNICAL EQUIPMENT CORPORATION
2548 West Twenty-ninth Avenue Denver, Colorado

BUYER'S GUIDE

Continued

887. Hypo sharpener

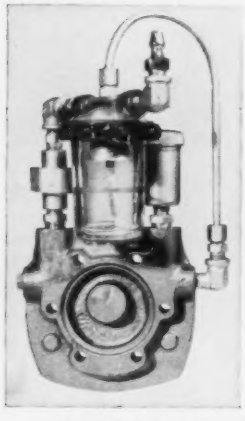


Pictured above is a motorized hypo sharpener in loading position. A scientifically correct point is produced every time. This sharpener takes all needles up to two inches in length except short bevel. Ordinary fishhooks are removed in seconds. There are two models—motorized and hand operated. Franz Mfg. Co.

888. Coreco color camera

The new Coreco Bucky color camera was demonstrated at the International Medical Research Corporation booth at the recent AMA meeting by Peter Bucky (l) to Guy Dillard, M.D., Columbus (Ga.) City Hospital and St. Francis Hospital, and John Thompson, M.D., St. Francis Hospital, Columbus, Ga. This camera enables an unskilled person to take standard pictures of high quality. It will take any medical picture except the retina, the inside of bladder and the stomach.

THIS Ingenious Little Device Ends Your Surgical Pump Problems—FOR GOOD!



Here's a nurse's eye view of the revolutionary Mueller Re-Circulating Oil System, which can save you so much time and eliminate so much equipment servicing in your operating room . . . *Automatically,* it maintains the pumps at top efficiency, with no constant checking, none of the frequent oiling most ether and vacuum units require. Throw away your oil can! You change oil in this unit only 3 or 4 times a year. *And that's all!*

The Re-Circulating Oil System (patented) is standard equipment in both the Herb-Mueller Ether-Vacuum Unit and the Mueller AS-29 Surgical Aspirator . . . and in these superior units only. Both are explosion-proof, of course—accepted in their entirety by Underwriters' Laboratories. Both are quiet, economical, utterly dependable. Let us tell you all they can do for you.

WRITE FOR FOLDER SP—TODAY

V. Mueller & Co.

The Pioneer Manufacturers of Ether-Vacuum Equipment

330 S. HONORE STREET CHICAGO 12, ILLINOIS

BRANCHES IN ROCHESTER (MINN.) • DALLAS • HOUSTON

889. Light by touch

Touchtron unit, when installed in base or body of portable lamp, causes lamp bulb to light or go out when given portion of lamp is touched. General Electric.

FILMS AND NEW LITERATURE

900. Contemporary lighting

A 64-page catalog containing full data on contemporary lighting fixtures. Includes lighting tables, lamp characteristics and F.T.I. reports. Kurt Versen Co.

901. Soap-detergent buying guide

Just published is a soap and synthetic detergent buying guide designed for institutional users of cleaning products. Pocket-size booklet gives data on toilet and bath soaps, pumice and liquid hand soaps, packaged synthetic detergents, scouring cleanser, flakes and granulated soaps in bulk containers. Colgate-Palmolive Co.

902. Nursing films

A new list of 25 films, with a brief description of each, is now available through the American Nurses' Association-National League of Nursing film service.

903. Eye instrument catalog

New comprehensive illustrated eye instrument catalog. New and popular patterns have been included. The Lawton Co.

904. Surgical instruments

Stainless steel, chrome plated surgical instruments are illustrated in this new catalog. H. Carstens Mfg. Co.

905. Test in personnel selection

Tests and other materials available for use in personnel selection and training are described in this industrial catalog. Helpful in locating materials to use in selecting employees, improving employee performance, and reducing turnover. Science Research Associates.

906. Decorating ideas

Here is a 12-page booklet, in color, that shows application of Vicrtex wall and furniture coverings in hospitals. Booklet describes the properties of Vicrtex, and includes a swatch to feel and examine. L. E. Carpenter & Co.

907. New tile booklet

Tile for Hospitals, a 24-page booklet of interest to hospital officials planning new construction or remodeling. Photographs and text explains how tile can contribute to greater sanitation, and reduce maintenance costs in hospitals. A valuable planning aid for hospital administrators. American-Olean Tile Co.

908. Steamcraft cookers

Describes the benefits of Steamcraft steam cookers designed for kitchens preparing from 50 to 200 meals. Lists advantages of cooking with steam for smaller establishments. Cleveland Range Company.

909. Ceiling catalog

New ways to increase lighting efficiency, economy, and design flexibility are suggested in fully illustrated brochure, *Luminous Ceilings Made with Bakelite Rigid Vinyl Sheets.* Many photographs. Bakelite Co.

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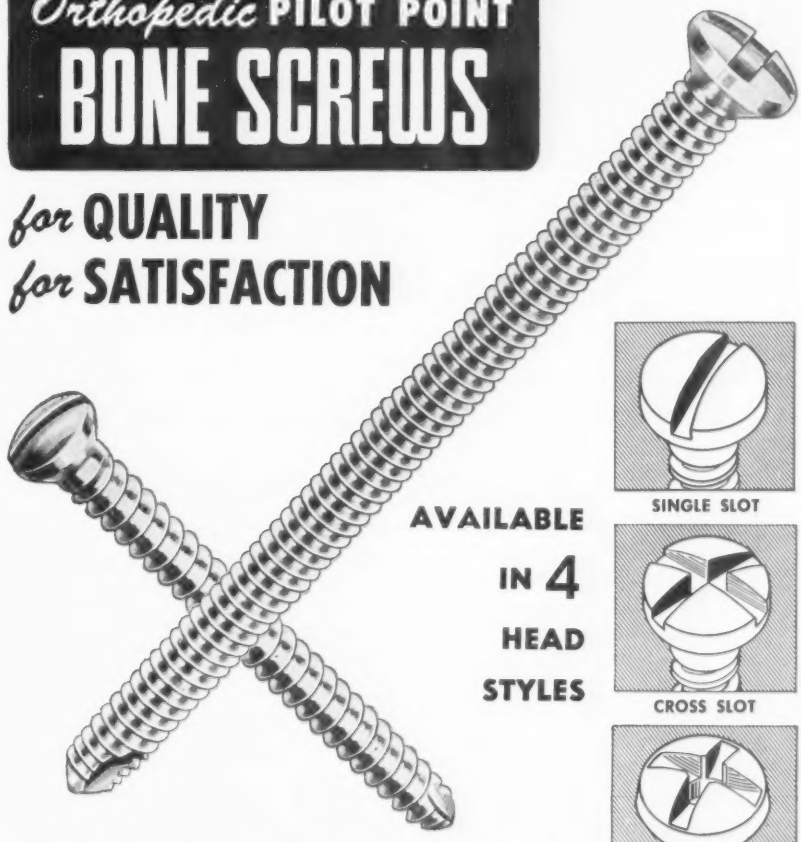
Orthopedic PILOT POINT
BONE SCREWS

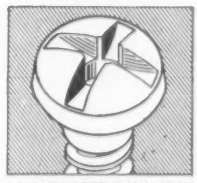
for QUALITY
for SATISFACTION

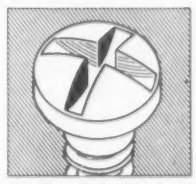


AVAILABLE IN 4 HEAD STYLES

SINGLE SLOT

CROSS SLOT


SIMULATED PHILLIPS


CONCAVE CROSS SLOT

Orthopedic bone screws are of stainless steel, have the proven pilot-point, are highly polished and free of particles . . . vital to exacting bone surgery. Available in fine and coarse threads; in the popular single slot, and 3 other head types designed to give a better bite and reduce the hazard of head slot mutilation.

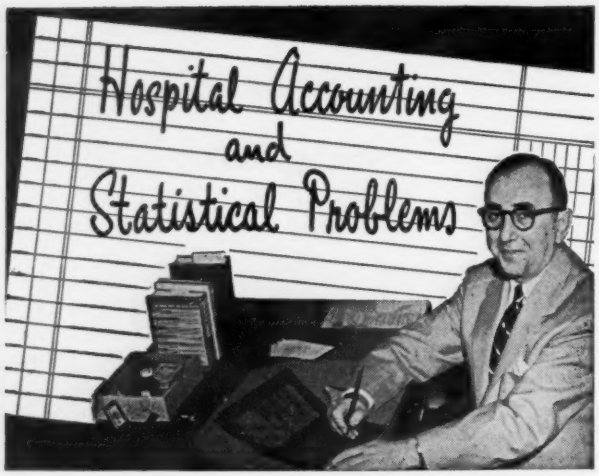
STANDARD LENGTHS: 3/8", 1/2", 5/8", 3/4", 7/8", 1", 1 1/8", 1 1/4", 1 3/8", 1 1/2", 1 5/8", 1 3/4", 1 7/8", 2".

LONGER LENGTHS: 2 1/4", 2 1/2", 2 3/4", 3", 3 1/4", 3 1/2", 3 3/4", and 4".

OTHER STYLES: 313—Eggers bone screws (used with 312 Eggers Bone Plates)—Sizes 3/8" to 2"—1/8" intervals.
126M—Modified bone screws—End threads are relief ground to give screw its own self-tapping point. Fine threads with 1/4" concave cross slot head. Recommended for use with 309 Slotted Bone Plate. Sizes 1/4" to 2"—1/8" intervals.

Order today, specifying head style, length and thread.

OEC *Orthopedic* EQUIPMENT CO.
190 FORT WAYNE ST. • BOURBON, INDIANA



By David H. Tarlow, C.P.A.

Senior Partner, D. H. Tarlow & Co.

Hospital Accountants and Auditors, New York City

Q. What should be the manner of handling accounts receivable sent to collection agencies? Is it advisable to charge these off immediately against the reserve for bad debts, or is it more acceptable to wait until the collection agency has definitely ascertained that the account is uncollectible? Can you give us any information regarding the procedures in use at other institutions?

A. We shall try to present the pros and cons for your guidance.

1. When write-offs are made immediately upon transfer to collection agency:
   - A. Conservative approach from balance sheet viewpoint is that accounts receivable listed are deemed to be collectible.
   - B. Separate control account is maintained in general ledger with adequate reserve for accounts in hands of collection agency.
   - C. Routine reports are requested regarding status of accounts from collection agency.
2. When write-offs are not made upon transfer to collection agency:
   - A. Balance sheet presentation may overstate value of accounts if such are included in one heading as current accounts receivable.
   - B. Less emphasis on collections may result if this item is not readily evident.

Regardless of which method you use, the complete write-off of the patient's account should be evidenced by a signature on the card of the superintendent, controller, or other authorized person, depending on the system of internal control in use at your hospital.

Q. How should securities be listed on a schedule for presentation to the board of trustees? We received a group from a legacy.

A. The following details would be pertinent:

a. Number of certificate if identifiable by such.

b. Number of shares or bonds.

c. Name of security.

d. Description. If stock, state whether preferred or common, and other details. If bonds, state rate of interest and maturity date. If notes, state principal, interest and maturity date. If mortgage documents, list complete description as to location of property, kind of property, principal balance, rate of interest, and maturity date.

e. Market value at date of acquisition. Obtain such value from authorized financial agency or newspaper publication.

Q. What is the value of a cut-off statement from the bank?

A. This method will tend to offset the three weaknesses which are evident in the monthly bank reconciliation, i.e.:

1. The list of outstanding checks are prepared at the close of the month from the cash disbursements journal, which may be in error as to one or more of the checks listed. Errors would be corrected as a result of a cut-off statement obtained after the balance sheet or closing date.
2. Deposits in transit are likewise listed from the cash receipts journal and may be in error.
3. Checks may have been drawn before the reconciliation date and not listed in the cash disbursements journal.

It is for that reason that many accountants include this routine as part of the regular audit program.

Q. We have recently obtained a formal appraisal of our buildings and equipment from an acceptable appraisal company. The values they report are in excess of that shown on our books. We are increasing our insurance coverage to meet this increase in valuation and want to effect the increase on our books of account. How should this entry be reflected on the books?

A. It is generally accepted in accounting practice that any increase in equity arising from a revaluation of assets should be clearly shown as such and not merged with the existing surplus or capital accounts. In other words, show the increase on the books arising from such revaluation as "Reserve for Plant Capital Due to Appraisal."

Q. We have several bonds in our investment portfolio which are not paying interest. If we include these with our other securities on our balance sheet, the resultant income yield appears too low. What procedure may we follow to point this up?

A. Bonds on which interest or principal or both have been defaulted should be listed on the balance sheet in a separate account pending final settlement. Usually such are deposited with a trustee pending final settlement, and it is suggested that you determine whether a trustee has been appointed for the bond issue.

Q. We have a cafeteria which is used almost exclusively by our employees. Since the charges are low, the cafeteria is run at a loss. The dietitian believes that this loss should be charged to administration rather than the dietary department. Do you have any suggestions as to how this loss should be treated?

A. We would recommend that you determine the number of meals served to the respective departments (Nursing, Housekeeping, Administration, etc.) and charge the loss to these departments in the ratio of meals served in the cafeteria.

Is your postoperative infection rate as low as this?

1.2 per cent infections among 6242 cases.[1]
0.9 per cent infections among 561 cases.[2]
0.6 per cent infections among 1211 cases.[1]
0.7 per cent infections among 296 cases.[1]

These results were obtained when pHisoHex was used routinely as a surgical "pre-op" hand scrub. No other scrub or wash has a *proved* record of clinical results in thousands of cases. pHisoHex is superior to all other scrubbing agents.[3-12]

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(pHisoderm® plus 3% hexachlorophene)

Winthrop-Stearns INC.
New York 18, N. Y. • Windsor, Ont.

References: **1.** Bowers, R. F., in discussion of Price, P. B.: *Ann. Surg.*, 134:476, Sept., 1951. **2.** Freeman, B. S.; and Young, T. K., Jr.: *Arch. Surg.*, 61:1145, Dec., 1950. **3.** Hopper, S. H.: *Bull. Am. Soc. Hosp. Pharmacists*, 10:202, May-June, 1953. **4.** Hopper, S. H.; Beck, A. V. R.; and Wood, K. M.: *Bull. Am. Soc. Hosp. Pharmacists*, 10:199, May-June, 1953. **5.** Zintel, H. A.; Ellis, Helen; and Garcia, Martha: Paper read at the Clinical Congress of American College of Surgeons, Chicago, Ill., Oct. 5-9, 1953. **6.** Cleland, Hugh: *Canad. Med. Assn. Jour.*, 66:462, May, 1952. **7.** Harrison, Elliott; and Cockcroft, W. H.: *Canad. Med. Assn. Jour.*, 66:110, Feb., 1952. **8.** Shay, D. E.: *Oral Surg., Oral Med. & Oral Path.*, 4:355, Mar., 1951. **9.** Dennis, E. W.: Unpublished data in the files of Sterling-Winthrop Research Institute. **10.** Dull, J. A.; Zintel, H. A.; Ellis, H. L.; and Nichols, A.: *Surg., Gynec. & Obst.*, 91:100, July, 1950. **11.** Allers, Olga E.; Hubbell, J. P., Jr.; and Buck, Ann S.: *Am. Jour. Obst. & Gynec.*, 60:431, Aug., 1950. **12.** Canzonetti, A. J.; and Dalley, M. M.: *Ann. Surg.*, 135:228, Feb., 1952.

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surface anesthesia
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NUPERCAINAL®

Contains Nupercaine® (dibucaine CIBA), one of the most potent and long-acting anesthetics.

Effective in low concentration —sensitization rare (nonnarcotic —not related to cocaine or procaine).

Useful whenever surface anesthesia is required—burns, surgical dressings, hemorrhoids, abrasions, etc.

Ointment (dibucaine ointment CIBA), 1% Nupercaine in lanolin and petrolatum base.

Cream (dibucaine cream CIBA), 0.5% Nupercaine in water-soluble base.

Ophthalmic Ointment, 0.5% Nupercaine in white petrolatum, applicator-tip tubes.

2/2091M

REVIEW OF HOSPITAL

LAW SUITS

By Leo Parker, Attorney at Law

A higher court recently rendered an important decision which clearly answers a legal question presented to me by various hospital officials during the past few months. Substantially, this question is: "What rule of law does the court recognize to determine who is liable in damages to a patient injured by a nurse anesthetist in the presence of a physician or surgeon, where the nurse is employed by the hospital?"

In Kemalyan v. Deaconess Hospital, 277 Pac. (2d) 372, the testimony showed facts, as follows: A woman named Kemalyan was a trained nurse who needed to have her tonsils removed. She was referred by her family physician to Dr. Henderson, an eye, ear, nose and throat specialist. Kemalyan was allergic to novocaine, and consequently asked to be given a general anesthetic (ether) rather than a local anesthetic (novocaine). Dr. Henderson arranged to have Kemalyan enter the Deaconess hospital. He arranged for the use of an operating room at the hospital and requested the hospital to provide an anesthetist to administer a general anesthetic.

Until the doctor entered the operating room immediately prior to going to the scrub room to sterilize his hands, he did not know which nurse anesthetist would be assigned. When Dr. Henderson entered the operating room Kemalyan was in the room, and he identified her as his patient to Esther Rudkin, the nurse anesthetist assigned by the hospital to administer the anesthetic. Miss Rudkin was a specialist in giving anesthetics, having taken a course to qualify her for that work. She had been actively engaged in her profession for more than 23 years, and had been so employed at Deaconess hospital for 20 years. She had previously served as anesthetist for Dr. Henderson many times; he considered her well trained and qualified.

After telling Miss Rudkin that Kemalyan was to be given a general anesthetic (which meant ether), Dr. Henderson left the operating room to go to the scrub room. Hospital rules required him to spend at least 10 minutes there sterilizing his hands. While he was out of the operating room, Miss Rudkin, as was her usual custom, began to put the patient (plaintiff) to sleep by anesthetic. The anesthetist first administered vinethene by the drop method using a facial mask, until Kemalyan "went to sleep." Then she connected a nasal catheter to the ether machine and inserted the tube in one of Kemalyan's nostrils, pushing the tube in a distance of between three and a half and four inches. The nasal catheter, or tube, was to be used to administer a mixture of ether and air directly into Kemalyan's lungs to keep her properly anesthetized during the operation.

Dr. Henderson seated himself and waited for the nurse-anesthetist to tell him that Kemalyan was ready to be operated upon. In about three minutes Miss Rudkin indicated that she thought Kemalyan was ready. The doctor got up and picked up a mouth gag, a metal instrument used to hold a patient's mouth open by mechanical means during a tonsillectomy. As the doctor and Miss Rudkin worked to insert the mouth gag in Kemalyan's mouth, Miss Rudkin decided that Kemalyan was not sufficiently anesthetized to start the operation, since there were still reflexes in her throat, and there was some difficulty in inserting the gag. Consequently, Miss Rudkin so advised the doctor and suggested that Kemalyan needed some more anesthetic. The doctor went back to the stool and sat down again. Miss Rudkin regulated the ether machine.

After about a minute, Miss Rudkin noticed that Kemalyan's abdomen seemed quite prominent and called the doctor's attention to that fact, then immediately turned off the ether machine and removed the nasal catheter. Kemalyan's tonsils were not removed. She was taken out of the operating room and placed in a hospital bed. When she regained consciousness, she discovered that her abdomen was greatly distended, and she was suffering from a great deal of pain and internal distress. X-rays later disclosed that free air and gas had somehow penetrated a viscus, either stomach or intestines, and had collected in the abdominal cavity. She was discharged from the hospital 11 days later, while her abdomen was greatly distended and she was still suffering a great deal of pain.

Kemalyan sued both the Deaconess Hospital and Dr. Henderson for heavy damages. First, it is important that readers realize from the above detailed testimony, that Dr. Henderson exercised no control over Miss Rudkin, and he did not instruct her in what to do.

Testimony during the trial indicated that Kemalyan's injuries were caused because Miss Rudkin, the nurse anesthetist, negligently allowed the nasal catheter to slip into Kemalyan's esophagus, or negligently allowed Kemalyan to swallow the catheter, or negligently failed to "anchor" the catheter so it could not slip into the esophagus. In other words, the only way the accident could have occurred would have been for the nasal tube to have dropped down into the esophagus, instead of remaining up in the pharynx where it belonged, thereby forcing into the stomach ether which should have gone into the lungs.

Hence, the court decided that Kemalyan's injuries were caused by Miss Rudkin's negligence. Dr. Henderson testified that Miss Rudkin knew considerably more about administering an anesthetic than he did, and that he left completely to her discretion the administration of the ether to Kemalyan.

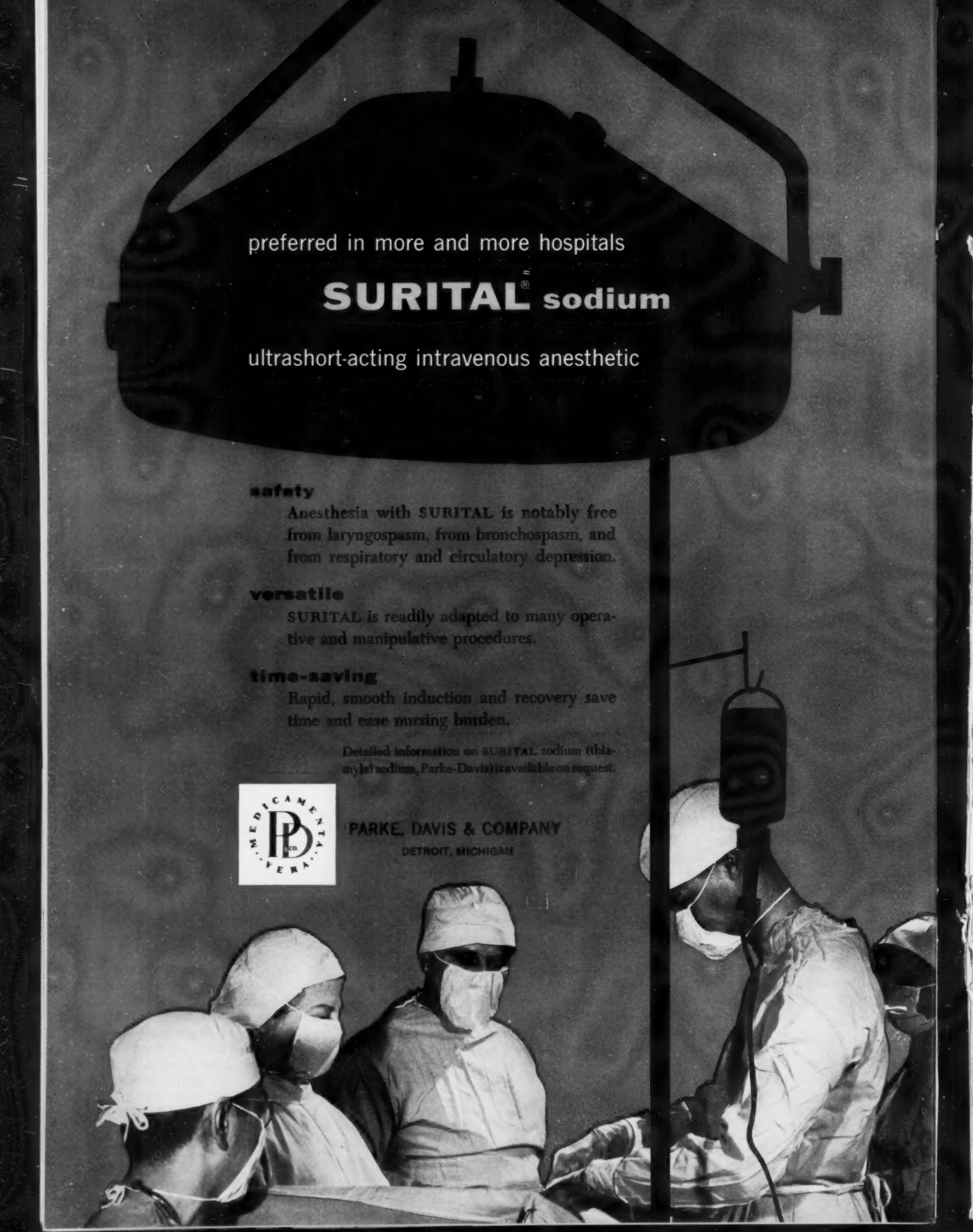
The higher court refused to hold Dr. Henderson liable, because the testimony clearly proved that he had no control over Miss Rudkin, and she was employed and paid by the hospital. In this respect, the higher court said:

"The testimony of the three surgeons as to the custom in the hospital constituted an evidentiary fact tending to prove that Dr. Henderson did rely on the nurse anesthetist and did not exercise any supervision or control over her actions as an anesthetist.

Therefore, Dr. Henderson was held not liable in damages to Kemalyan solely because Miss Rudkin was not directed what to do by Dr. Henderson, and he had no control over her during administering of the anesthetic.

Testimony showed that Miss Rudkin was in the employ of the hospital corporation, which paid her salary. The counsel for the hospital argued that actually she was not the "agent" of the hospital, but was a "loaned servant" who was the agent of Dr. Henderson during the administration of the ether to Kemalyan. The lower court refused to agree with this contention and held the hospital liable in $6,051.54 damages to Kemalyan. The higher court approved the verdict, saying:

"There was ample evidence from which the jury concluded that the nurse anesthetist was not the agent of the doctor but was in fact the agent of the hospital."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Left: Pictured together are (l. to r.): Barbara Isbell (MT, ASCP), San Diego, Calif., 1955-56 president; Lucille Godelfer (MT, ASCP), New Orleans, La., convention chairman, and Ruth Hovde (MT, ASCP), Minneapolis, Minn., 1954-55 president.

ASMT Meets in New Orleans

• Delegates to the 23rd annual convention of the American Society of Medical Technologists which met in New Orleans June 12-17, voted to extend membership to students from approved schools, and made plans for launching an extensive membership drive within the profession.

The delegates also voted to recommend to the Board of Registry of the American Society of Clinical Pathologists that—beginning in 1960—all applicants to schools of medical technology have at least a Bachelor of Science degree in required science courses. The ASMT advisory council voted to continue the study of laboratory aids and to study the status and function of the board of approved schools.

First place winners of the Scientific Products Foundation Awards were: Ann Carol Unseth (MT, ASCP), Minneapolis, Minn., for a paper titled, "Flame Photometry in the Clinical Laboratory"; Wayne A. Stenback (MT, ASCP), Denver, Colo., for a paper titled, "Blood Media for the Cultivation of Mycobacterium Tuberculosis"; Genevieve Stout (MT, ASCP), Decatur, Ga., for a paper titled, "Presumptive False Positive Serolotic Reactions for Syphilis in Central America"; Kathryn Ann Grave, (MT, ASCP), Minneapolis, Minn., for a paper titled, "Observations on the Lipoid Granulation of Cells of Human Blood and Bone Marrow by Means of Suden Black B Staining Technics"; Kathleen J. Clayson (MT, ASCP), Minneapolis, Minn., for a paper titled, "Experience with the Reddy Method of 17-Hydroxycorticoids in Urine in a Clinical Chemistry Laboratory"; Jane F. Taylor (MT, ASCP), Columbus, O., for a paper titled, "Cross-Matching the Uncross-matchable Recipient."

ASMT awards were presented to Jane Taylor (MT, ASCP), Columbus, O.; John Alvarez (MT, ASCP), Tampa, Fla.; and Bernice Elert (MT, ASCP), St. Paul, Minn. The prize for the best exhibit by an ASMT member went to Lucille Godelfer (MT, ASCP), New Orleans, La., for her exhibit on "Enteric Bacteriology."

Papers presented at the meeting included the following: "The Signifi-

(Continued on next page)

Below: New ASMT officers for 1955-56 are (l. to r.): Ruth Heinemann (MT, ASCP), Minneapolis, Minn., elected to the Board of Directors; Sister M. Simeonette (Savage) (MT, ASCP), Louisville, Ky., elected to the Board of Directors; Barbara Isbell (MT, ASCP), New Orleans, La., president; C. Patton Steele (MT, ASCP), Bismarck, N. D., president-elect; Ellen Anderson (MT, ASCP), Chapel Hill, N. C., recording secretary.

cance of the Direct and Indirect Coomb's Test," by Charles C. Sprague, M.D., Associate Professor of Medicine, Tulane University School of Medicine, New Orleans, La.; "Laboratory Aids in the Diagnosis of Leprosy," by Sister Hilary Ross, Biochemist, and Rollo R. Wolcott, M.D., U. S. Public Health Service Hospital, Carville, La.; "Amperometric Titration of Chloride in Tissue, Serum Urine, and Feces," by Ben E. Hallaway (MT, ASCP), Research Assistant, Hospital Laboratories, University of Minnesota, Minneapolis, Minn.

Instrumentation clinics on Calibration, Ph and Potentiometry with Titration, Flame Photometry and Spectrophotometry, were held on Tuesday, June 14. A parasitology refresher course was also given.

Lift for Polio Victim

A light-weight midge winch, especially designed for a Tulsa, Okla. poliomyelitis patient, may provide relief for helpless victims everywhere.

The metal lift was built especially for a 21-year-old graduate nurse who wanted a device that would facilitate moving her when she became completely paralyzed. The rig weighs less than five pounds, and can hoist 200 times its weight.

Census of Foreign Doctors

Five thousand thirty-six physicians from 84 foreign countries trained in American hospitals as interns or residents, according to *Open Doors*, the annual census of foreign exchanges in the United States.

The physicians surveyed all trained in hospitals approved by the American Medical Association for internship or residencies. Over a quarter of the visiting doctors came from Far Eastern countries. Latin Americans and Europeans each represented about one-quarter of the total.

Sixty-five percent of all foreign doctors took advanced training with resident status, and 1,761 were interns. Among the doctors from Canada and the Near and Middle East, an unusually high proportion were residents; the European doctors, on the other hand, included a high percentage of interns.

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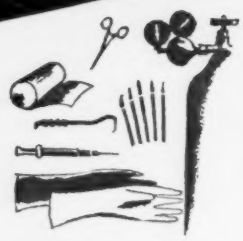

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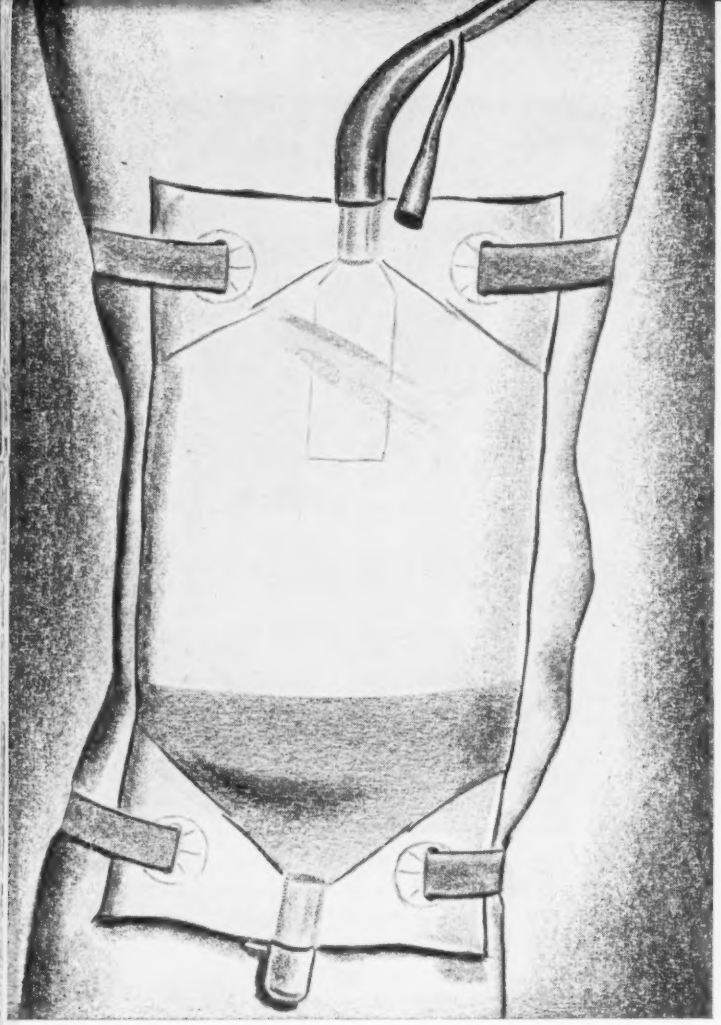

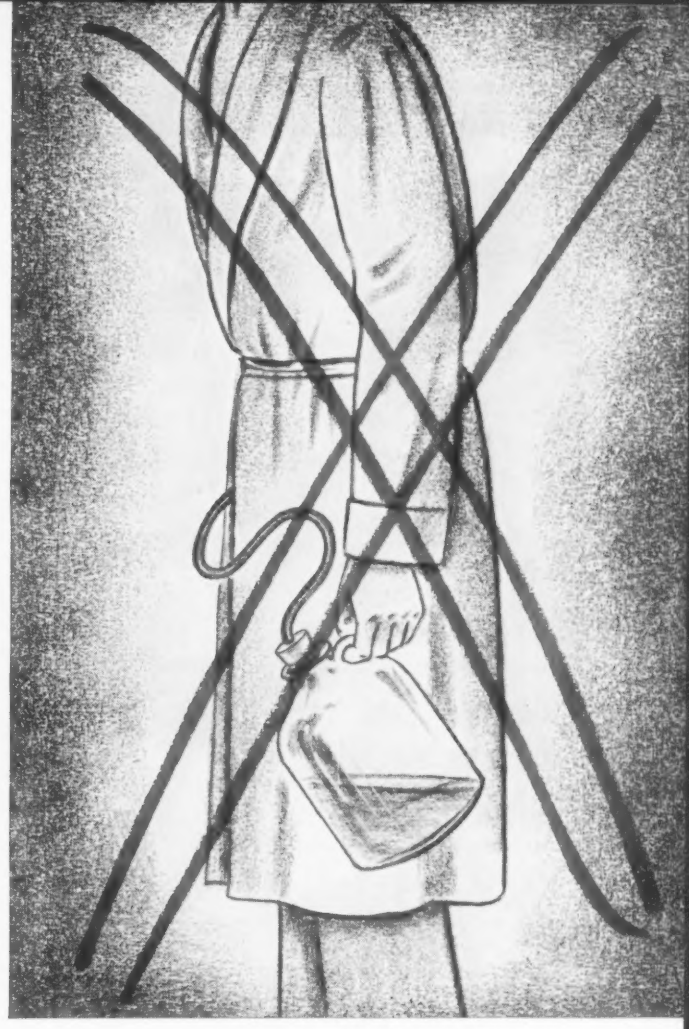

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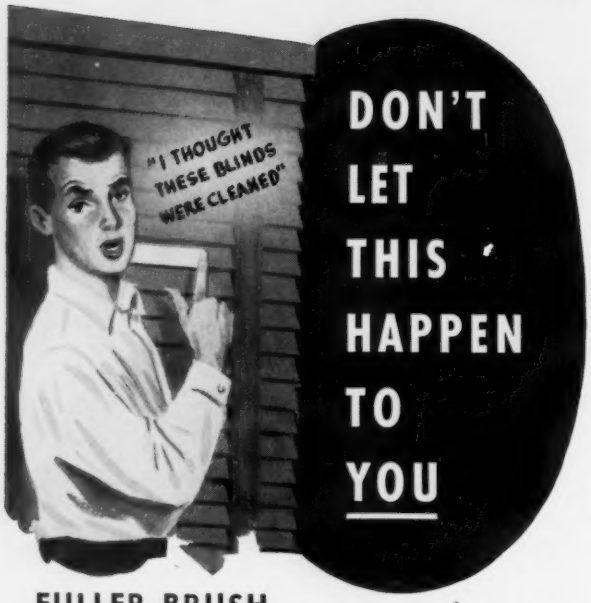

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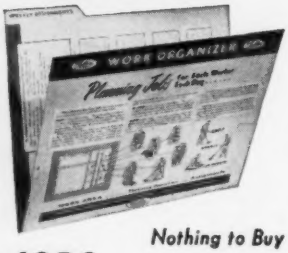

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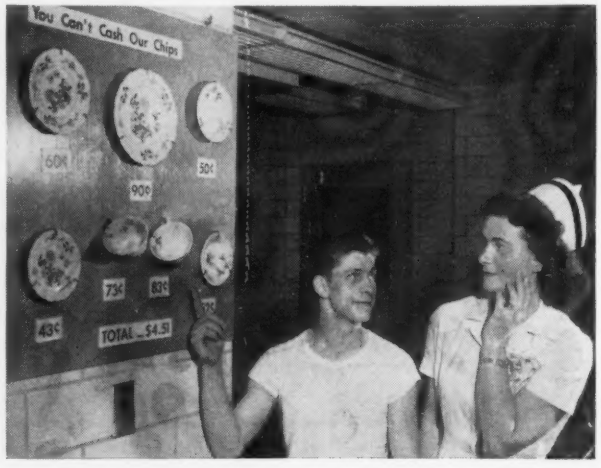
Health Insurance in America

Total of benefit payments on health insurance claims reported by a survey made by the Health Insurance Council, New York, exceeded $2.7 billion in 1954, a gain of 11 percent over the previous year.

Of the aggregate benefit payments in 1954 by all forms of voluntary health insurance, 56 percent of the total came from the insurance companies. The dollar amount paid by the companies was over $1.5 billion, including loss-of-income benefits.

Blue Cross and Blue Shield type plans paid more than $1 billion, or 39 percent of the total. Various independent plans accounted for the remainder.

Below: Robert Wilson, of the dishwashing crew, St. Charles Hospital, Toledo, Ohio, points out that dishes can be broken by mishandling on the upper floors of the hospital as well as in the kitchen to Virginia Keller, R.N. The display, recently placed in the dishwashing room, used some of the chipped mistakes which were unsuitable in food service. Visible reminder has proven effective in cutting down breakage, the administration reports.



Above: J. Russell Clark (l.) presents the gavel to Thomas Hale, Jr., M.D. at the Middle Atlantic Hospital Assembly which met in Atlantic City in May. Mr. Hale is the new president of the New York Hospital Association.

U. of C. Graduates Receive Appointments

Twelve University of Chicago students in hospital administration have been appointed to administrative residencies as follows:

Warren G. Ball, M.D., to G. Otis Whitecotton, M.D., medical director, Highland-Alameda County Hospital System, Oakland, Calif.; **Lyle N. Buckles,** to Hubert W. Hughes, administrator, General Rose Memorial Hospital, Denver, Col.; **Denison K. Bullens, Jr.,** to George H. Buck, administrator, Nassau Hospital, Mineola, N. Y.

David W. Clark, to Stanley A. Ferguson, superintendent, University Hospitals, Cleveland, O.; **Richard L. Durbin,** to Everett A. Johnson, superintendent, Gary (Ind.) Methodist Hospital; **Richard D. Gifford,** will enter the armed forces.

John M. McIntyre, to J. Milo Anderson, administrator, Strong Memorial Hospital, Rochester, N. Y.; **James Paton,** to Karl S. Klicka, M.D., administrator, Presbyterian Hospital, Chicago, Ill.; **Philip K. Reiman,** to position as assistant administrator, St. Luke's Hospital, Saginaw, Mich.

Henry Veldman, to Alexander Harman, superintendent, City Hospital, Cleveland, O.; **Robert A. Walker,** to Reid T. Holmes, administrator, North Carolina Baptist Hospital, Winston-Salem, N. C., and **Richard D. Wittrup,** to position of administrative assistant, University of Chicago Clinics.

VA Conducts Studies on Mental Condition of TB Patients

Psychologists are working with physicians in VA hospitals to determine what TB patients think about that may aggravate their condition and what may be done to prevent or counteract such thoughts.

Studies are being conducted in 14 of the VA's 21 TB centers and in many of the VA's psychiatric and general medical hospitals which have TB wards.

The VA estimates that one-third of all TB patients leave the hospitals against medical advice before their treatment is complete.

Failure of patients to tolerate hospitalization makes their cure uncertain and endangers the lives of others with whom they come in contact.

Prize Money Distributed In VA Writing Contest

More than 200 veterans in VA hospitals have been awarded $5,000 worth of prizes in the ninth annual nationwide writing contest sponsored by the hospitalized veterans writing project. Veteran patients submitted a record-breaking 1,500 entries.

Boston VA hospital won a set of the Encyclopedia Americana for the best report on hospital writing activities submitted by a patient.

A hospital in Sunmount, N.Y., received an electric typewriter for the best article by a patient on "Writing for Rehabilitation," as chosen by Howard Rusk, M.D., associate editor, *New York Times.*

Atlanta Institute On Hospital Pharmacy

Emory University will be host to the Atlanta Institute on Hospital Pharmacy from August 22-26.

Robert Fischelis, Austin Smith, M.D., Grover Bowles, and Herbert Flack are a few of the faculty of 28 national leaders.

Registration is limited to 100.

A total of nearly 39,000,000 workers had protection at the close of 1954 against loss of income due to disability. This figure represents about 60 percent of the total civilian labor force in the nation at the time.

The newest form of voluntary health insurance—major medical expense insurance—is shown by the survey to protect more than 2,200,000 persons against the costs of catastrophic illness. This figure represents a gain of 83 percent over the previous year.

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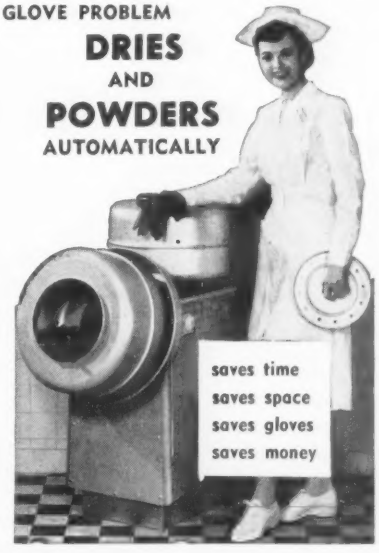

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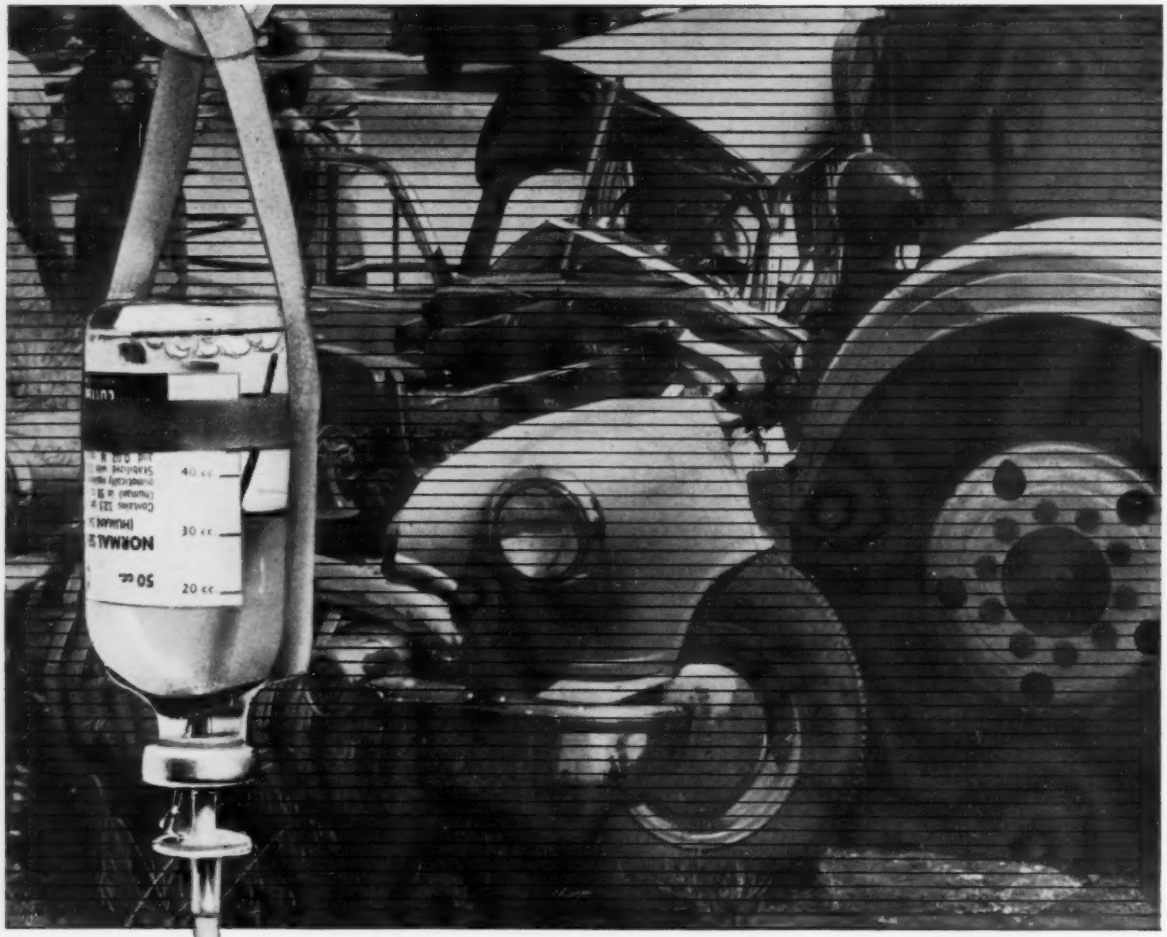

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Philadelphia Nurses Plan ICS Sessions

● Members of the Pennsylvania A.O.R.N., under the direction of President Pauline R. Young, O.R.S., Hahnemann Hospital, Philadelphia, are helping to plan sessions for surgical nurses and central supply supervisors at the International College of Surgeons' congress in Philadelphia, September 12-16.

Shown above at a recent committee meeting are (l. to r.): Miss Young; Margaretta Over, O.R.S., Bryn Mawr (Pa.) Hospital; Kyle Laramore, O.R.S., Woman's Medical College and Hospital, Philadelphia; and Marian Young, O.R.S., University of Pennsylvania Hospital, Philadelphia.

The program for the sessions, which will be held in the convention hall, appears on page 66. In addition, the local committee is planning tours for Friday, September 16.

There will be no registration fee for nurses. Further information may be obtained from the general chairman, Laura G. Jackson, coordinator of public relations, International College of Surgeons, 1516 Lake Shore Dr., Chicago 10.

At right: Irene Kuntz, O.R.S., Lankenau Hospital; Helen Steele, O.R.S., Northeastern Hospital; Elizabeth McAleese, O.R.S., VA Hospital; Norma Ciambella, operating room staff, Woman's Medical College and Hospital, and Bea Hunsberger, O.R.S., Methodist Episcopal Hospital, all of Philadelphia.

International College of Surgeons

Surgical Nurses' Sessions

MONDAY, September 12

10 a.m. - 12:15 p.m.

Opening Remarks

Max Thorek, M.D., Founder and International Secretary General, International College of Surgeons, Chicago

Latest Trends in Orthopedic Surgery (illustrated)

Irving Stein, M.D., Chief of Orthopedics, Philadelphia General Hospital

Cardiac Surgery

Charles P. Bailey, M.D., Professor and Head, Department of Thoracic Surgery, Hahnemann Medical College and Hospital, Philadelphia

2 - 5 p.m.

Thalamotomy

Henry Wycis, M.D., Clinical Professor of Neurosurgery, Temple University School of Medicine and Hospital, Philadelphia

Hydrocephalus and Its Surgical Management

Axel Olsen, M.D., Chief of Neurosurgical Department, Hahnemann Medical College and Hospital, Philadelphia

Newer Trends in Neurosurgery

O. H. Fulcher, M.D., Professor of Neurological Surgery, Georgetown University, Washington, D.C.

Electroencephalography

T. C. Barnes, D.Sc., Associate Professor of Pharmacology, Hahnemann Medical College and Hospital, Philadelphia

TUESDAY, September 13

9:30 a.m. - 12 noon

Discussion from different countries of nursing technics in operating rooms

Pros and Cons of Student Training in Operating Rooms

Who Is in Charge of the Recovery Room?

Harold W. Maysent, Assistant Director, Lankenau Hospital, Philadelphia

2 - 4 p.m.

Retinal Detachment

Technics presented by personnel of Wills Eye Hospital, Philadelphia

WEDNESDAY, September 14

9:30 a.m. - 12 noon

PANEL DISCUSSION: Central Supply Room in Cooperation with Operating Room

Moderator and Introductory Speaker:

Mary Helen Anderson, R.N., Central Service Supervisor, Grant Hospital, Chicago

Participants:

William Hill, Technician in Charge of Central Supply Room, Jefferson Hospital, Philadelphia

Cecilia Yastremski, R.N., Supervisor, Central Supply, Hahnemann Hospital, Philadelphia

Kyle Laramore, R.N., Operating Room Supervisor, Woman's Medical College and Hospital, Philadelphia

Ruth Boyer, R.N., Supervisor, Central Supply Room, University of Pennsylvania Hospital, Philadelphia

Lt. Jean Davis, N.C., Operating Room Supervisor, U.S. Naval Hospital, Philadelphia

2 p.m.

Tour through plant of George Pilling & Son Co.

THURSDAY, September 15

9:30 - 11:30 a.m.

Architectural Set-up of an Operating Room Suite

Speaker to be announced

Operating Room Procedures: General Administrative and Medico-Legal Aspects

Charles U. Letourneau, M.D., Associate Professor and Director, Program in Hospital Administration, Northwestern University, Chicago

The Surgeon's Viewpoint of Teamwork in the Operating Room

Vice Adm. Ross T. McIntire, M.C., U.S.N. (Ret.), Executive Director, International College of Surgeons, Chicago

1 p.m.

Tour of plant of Sharp & Dohme, Inc., West Point, Pa. Bus transportation provided from convention hall

New Trends in Surgery

(Here are two more discussions from the New Trends in Surgery *panel held at the A.O.R.N. convention in St. Louis in January. Others appear on page 70 of the July issue of* HOSPITAL TOPICS*).*

Pediatric Surgery

● The newest, most dramatic trends in pediatric surgery are above the diaphragm. But there is a new trend below the diaphragm which is my particular field. I think I can summarize that trend by saying that abdominal surgeons have now adopted a more aggressive attitude toward surgical intervention in infants, even in the newborn and in prematures, with the idea of saving life and achieving many other therapeutic benefits which have not been available in the past.

This trend is due to many things. One of them is the explosion of several myths—that a baby can't stand an operation, that the psychic trauma for a child is too great and may exert a bad influence in later life, or that the baby lacks resistance. These myths, I think, are based largely upon sentimentality.

Actually, even premature babies are endowed by God with a tremendous vitality so that they can stand extensive abdominal procedures. So the mortality now is relatively low, and the risk is scarcely less than in later life. But this recognition that one can save life by adopting a more aggressive attitude has also been due to the fact that many technical difficulties have been overcome.

Some technical difficulties are apparent only to those not accustomed or trained to operate on newborn or small babies; others are real but are now being overcome.

Among the technical advances are certain pre-operative preparations or procedures, one of which is prompt uses of gastric gavage. Babies are so prone to aspirate their gastric contents, even without any particular premonitory signs, that it is very important to keep the stomach empty by means of adequate gastric gavage, not only before but during and after operation.

Chemotherapy when used critically has also played a very important part. A knowledge of blood, food and fluid needs in the infant is essential, so much so that it is almost routine now in all significant abdominal operations for a cut-down to be instituted before the patient reaches the operating room or before the anesthetic is started.

Years ago I used to have a good deal of difficulty getting instruments that were small enough for these little babies. In spite of all my efforts in setting up a special pediatric tray, I still got Kelly clamps just about as large as the patient. The suture material was a difficult problem. We used to borrow the iris needles and fine silk from the ophthalmic surgeons, but since cardiovascular surgery has developed we use the arterial silk which I find very effective.

During the course of the operation we have learned also that one must be bold and aggressive. For example, it is essential in many cases to completely eviscerate the entire contents of the abdomen in order to find and correct the nature of the lesion responsible for the obstruction. Such exposure also permits more definitive procedures, aided of course by excellent anesthesia.

These new trends can best be exemplified by describing a few examples. Many years ago many babies died of general peritonitis due to gastrointestinal perforations, largely because it was very difficult to make a diagnosis. We now recognize that perforations may occur in infancy and the newborn, with very few clinical manifestations, and that prompt operation will save many of these lives. Acute appendicitis is a common cause, which I mention only because there is still a tendency to believe that it can be treated medically.

Sir William Osler many years ago said, "There is no medical treatment for acute appendicitis," and that is particularly important in children in whom the signs and symptoms may be atypical and perforation and general peritonitis may lead rapidly to a fatality.

With the aid of chemotherapy the operation has become much safer. I don't believe we've lost a single case of acute appendicitis in the last five or 10 years, whereas previously the mortality in the perforated cases with peritonitis was as high as 30 and 40 percent.

Inguinal hernia is another common condition in which a more aggressive attitude has resulted in the saving of life and the relief of much disability. It is safer now to operate on a baby than it is for the baby to have the

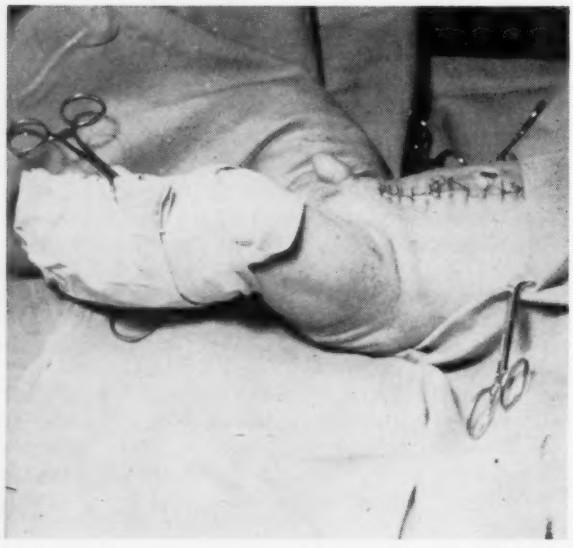
(Continued on next page)

risk of strangulation. We no longer wait until the child is five or six years or even one year of age; a hernia can be easily and safely treated in infancy. In fact, there are many reasons to believe that it is better to operate on hernia in infancy than later. Certainly the use of trusses in children has no place at all.

We have had no deaths from hernia operation in infancy except in the few cases in which strangulation has occurred.

There are other examples. One is intestinal obstructions at birth, particularly in the premature. We have learned that procrastination really leads to disaster in many cases, and that prompt operation is urgent and often rewarding.—**Robert Elman, M.D.**, professor of clinical surgery, Washington University School of Medicine, St. Louis.

Below: An abdominal perineal operation for a high-lying imperforate anus. This operation was done within 24 hours of birth, and the entire defect was corrected at one sitting. There has been no mortality in the last 12 cases in which this procedure has been done. Cut down is on the right leg. The skin can be sterilized down to the toes. The perineum and the abdomen are prepared at the same time.



Cardiovascular Surgery

In considering developments in cardiovascular surgery during the past 15 years, one might itemize a large number of operations and discuss progress related to each operation. However, we shall confine our attention to three main aspects of the subject: hypothermia, a physiological alteration in the patient; the heart-lung machine, a physiological substitute for the heart and lungs, and grafts of various sorts, anatomical substitutes for the parts of the cardiovascular system.

Hypothermia literally means low temperature. In modern practice it means the reduction of the patient's general body temperature by a significant amount. The normal body temperature is in the neighborhood of 98.6 Fahrenheit. Strictly speaking, if we reduce our temperature to 97, that constitutes hypothermia. This technic of lowering the body temperature slightly has been and continues to be useful. However, hypothermia today usually means temperature below 90° F. down to levels as low as 68 or 70° F. and sometimes even lower.

Such a degree of temperature reduction brings up entirely different problems than the slight reductions. The lesser degrees of temperature reduction in the patient, down to levels of 90 or above, are useful in preventing the opposite trend of the patient's temperature during the hot weather such as we experience in St. Louis during the summer. In order to prevent the patient's temperature from rising unduly, we may place him on an ice-water mattress which keeps his temperature at normal levels or even several degrees below.

The modern interest in hypothermia was initiated by Bigelow, a Toronto surgeon and physiologist, who reported several years ago that he had reduced the body temperature in dogs to between 68 and 78° F. (20-25° C). With body temperature at this level, it had been possible to stop the heart action of these dogs for 15 minutes with subsequent complete recovery of the animals. These animals recovered because the lowered temperature diminished the oxygen needs of their brain and other organs in such a pronounced fashion that these organs were not irretrievably damaged by the cessation of heart action and the absence of oxygenated blood during the period of cardiac arrest.

This report of Bigelow set off a wave of investigation which is still going on in an attempt to determine the fundamental physiology of hypothermia.

In his initial report, Bigelow also commented on the possible bad effects of this technic. One of the most obvious was ventricular fibrillation or incoordinated beats of the heart so that the heart, while active, is not propelling blood forward through the circulatory system.

When one gets the patient's general body temperature down to levels of about 80° F., the likelihood of fibrillation is considerable; if the temperature is carried down into the sixties the likelihood is extremely great, particularly if the heart is being manipulated at the same time.

When fibrillation of the ventricles occurs during cardiovascular or other surgery in the heart at normal temperature, it may be a relatively simple matter in

Left: Through an abdominal incision, the colon is dissected out, its communication with the bladder or the vagina is identified and severed, and then the colon is brought down into the perineum and sutured. Often by the time the patient gets back to the ward he has a normal meconium stool.

some patients to revert this abnormal rhythm to normal. This can be accomplished by periodic compression of the heart so that the pumping action is maintained artificially and the heart may then return to its normal rhythm. In most cases, however, it is necessary to apply electrical shock to the heart, to stop completely the abnormal muscular activity. After the heart has been reduced to a complete standstill, compression by the hand in a rhythmic fashion usually will return the normal beat of the heart within a relatively short time.

This correction of ventricular fibrillation is a relatively easy matter in the warm heart which has no inherent abnormalities. On the other hand, in abnormal hearts and particularly in hearts which have been cooled to a pronounced degree, the restoration of a normal co-ordinated beat may be very difficult.

Hypothermia has been used extensively in many operating rooms, and there are various ways of accomplishing it. In Bigelow's original work, he employed a special blanket through which a coolant was circulated which lowered the patient's skin temperature first. Gradually the temperature of the entire body dropped. After the patient was removed from the cooling blanket, his temperature tended to go down a little farther. In using this technic, if the cooling is stopped at 75 or 80° F., the temperature may be expected to go several degrees lower during the ensuing half hour.

With every degree Centigrade that the body temperature is lowered, the basal metabolic rate drops about 5 percent. Consequently, if someone's temperature is lowered 10 degrees Centigrade, his basal metabolic rate or oxygen needs will be dropped about 50 percent.

It is known that if the heart stops for four minutes, more or less, and oxygenated blood is not pumped to the brain at normal temperatures, the patient will suffer irreparable damage. This interval can be considerably prolonged without such damage if the patient's general temperature is lowered. The heart action and respirations slow down until respiration finally stops and has to be maintained artificially. As one rewarms the patient, spontaneous respirations are again resumed.

In ordinary laboratory rats cooled down to 5° C. (approximately the temperature of a home refrigerator) the heart can be stopped for 30 minutes, and the rats probably will recover. If the heart is stopped for an hour to three hours, about half the rats will recover. If it is arrested longer than three hours none will recover. These results cannot be transferred to man, but they do give us additional information about the mechanism by which hypothermia gives protection in certain animals.

In addition to using cooking blankets, one may cool the patient by placing him on ice-water mattresses, on ice bags, and even in a bathtub of ice water in the operating room. I am sure that operating room supervisors generally would consider bathtubs in the operating room as undesirable. However, they are used and function efficiently even if they are somewhat messy.

HEART-LUNG MACHINES

Work with heart-lung machines will always be associated with John Gibbon of Philadelphia. For approxiately 20 years he has expended tremendous effort and very large sums of money to develop a machine which would substitute for the pumping action of the heart and for the oxygenating function of the lungs. To provide a pump is relatively easy, and to prevent the clotting of blood in the apparatus is also not unduly difficult. However, artificial oxygenation of the blood is more troublesome. Some of the practical problems concern the danger of hemolysis or breaking down of the red cells, the risk of infection (which is no longer a problem when one can sterilize reliably all parts of the apparatus) and, finally, the disturbances in coagulability of the blood, which are brought about in some obscure way by passage through this machinery.

There is a deliberate attempt to render the blood incoagulable in order to prevent it from clotting in the apparatus. However, after the effect of heparin has been reversed by appropriate medication and the patient has begun to recover successfully from his operation carried out with the aid of the heart-lung machine, a bleeding tendency may develop which cannot be controlled, and in some instances death has resulted.

Work is continuing on the solution of these and other problems, such as the prevention of foaming of the blood, the substitution for the lungs alone, the substitution for the right or left side of the heart alone, and the studies on relation between bacterial contamination and the use of these devices.

Most operating room nurses are familiar with the success achieved by Minnesota surgeons with use of a donor who oxygenates the blood for the patient while the heart and lungs are removed from effective circulation so that the heart may be opened and repaired. In this technic, the healthy adult donor, who is usually the patient's mother or father, is anesthetized in the operating room alongside the patient, and the unoxygenated blood is drawn from the patient with a pump passed into the venous system of the donor and oxygenated by the donor. Then it is drawn off from the donor's arteries and pumped back into the patient's arteries. The patient in effect gets blood which is a mixture of his own blood and the donor's blood, all of which is being oxygenated by the donor.

The risk to the donor has raised some questions. Dr. Varco, who has been associated with Dr. Lillehei and others in this work at Minnesota has stated that one should not consider it unusual if a mother or father undergoes some risk to save the life of a child. Such a risk is gladly assumed, with full knowledge by the parent, when the mother originally has the child, as well as in certain other circumstances. There have been no deaths among any of the donors used in employing this technic.

GRAFTS

By grafts we ordinarily mean blood vessel grafts. In blood vessel grafting we take an aorta, let us say, or a femoral artery and replace it with the aorta or femoral artery of another person. This work, done by Carrel at the turn of the century, was revived and put on a solid foundation by the work of Dr. Robert Gross and his associates. In their original work the grafts were taken from donors under very careful bacteriological conditions and were preserved in nutrient media designed to maintain their viability for 30 or 40 days. In the beginning it was believed that these grafts should be viable, but it has since been learned that so-called viability is not necessary, since one may kill the graft by formalin, by sterilizing agents, and in various other ways, and still have it function effectively as a conduit for blood.

One may remove a blood vessel which is to be used as a graft under either sterile or unsterile conditions. If it is removed under sterile conditions, an attempt is

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Above: Nurse's station is in the middle of unit. Door at far end leads to operating room suite. On the same side of the corridor as the nurse are two two-bed units. One in foreground is an isolation unit that contains its own sink and has an ultra-violet ceiling lamp. This unit is used for patients recovering from tuberculosis pulmonary resection. The hospital has a great deal of these cases. Patients are put in the unit with their own nurses. At left of nurse's station is another two-bed unit used frequently for pediatric surgery. It contains an Isolette unit, and can accommodate three children or two adults. Across the corridor are four sealed units, walled in up to a height which permits nurse to see all patients at all times.

Planning and Management of the Recovery Room

By Elliott Hurwitt, M.D.
Chief, Surgical Division
Montefiore Hospital
New York City

(The following paper was presented at the A.O.R.N. convention held in St. Louis, January 24-27, 1955.)

• My material has been divided into five basic questions in reference to a recovery unit: WHY, WHERE, HOW, WHO, and HOW BIG.

The answer to WHY is not hard to find. I was under the mistaken impression that the modern interest in recovery suites stemmed from our experiences during World War II, when all of you who had an opportunity to work in military installations became acquainted with the tremendous advantages of having a shock ward, a receiving ward, a recovery ward, where patients could go after surgery and remain under the supervision of nurses specifically assigned to these units. Even on the Navy hospital ships at sea, we took advantage of this opportunity, and it made an enormous difference in the handling of patients. So I was surprised when Miss (Edith Dee) Hall told me that when she was a youngster about my age every hospital had recovery units—that this idea had been tried, and for some reason not completely understood, had not been continued.

But I think it required the lessons of this last war, particularly the tremendous advances made in resuscitative therapy, the availability of blood transfusions, antibiotics, parenteral fluids, and oxygen therapy—all these things, concentrated in a recovery unit, to give the unit great meaning.

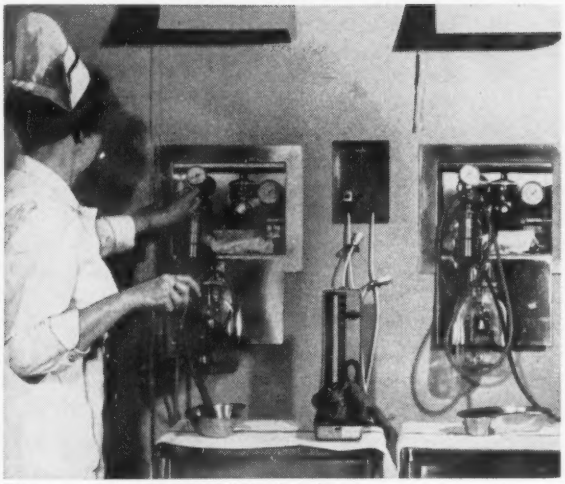
So the WHY of a recovery unit is to set up a place where patients after undergoing surgery can be concentrated in a unit that will be thoroughly equipped; that will be staffed by a permanent staff of recovery room nurses; that will eliminate transporting unconscious or semi-conscious patients through hospital corridors, letting them get stuck in elevators, or be exposed to drafts, or swallow their tongues when there's nobody around to pull the tongues out; that will prevent them from going into shock in transit with nobody or nothing available to correct the situation.

I'm sure all of you, if you think hard enough, can remember at least one, perhaps several, instances in which patients, after leaving the operating room in apparently good postsurgical condition, were dead by the time they reached their rooms on a floor that could be a short distance or a long distance from the operating room.

Such sudden deaths have occurred after very simple operations, after herniaplasties, after gallbladder operations. I can recall a hysterectomy patient to whom this happened.

These tragedies can be eliminated by having a recovery unit. If one patient is saved by such a setup, you need no other reason why the unit is no longer a luxury, but a necessity.

The next question is "WHERE should the recovery unit be?"



Picture courtesy Parade Publication, Inc.

Above: Closeup of one of the rooms with two units, showing wall oxygen and suction outlets, blood pressure apparatus, overhead lights, and, between oxygen and suction equipment, an intercom (Executone) which connects with nurse's station, permitting nurse to hear patients breathe or groan, to hear their every request.

There's no such thing as a universal blueprint for a recovery unit, that each of you could adapt to your particular hospital. The plan will depend on the physical construction of your hospital; on available space; and, to a large extent, on the type of case load that your particular hospital handles, because concentrations of different kinds of material in different hospitals make different needs arise, and I will illustrate that a little further on.

Our recovery unit is all on one floor level, the ground floor, which makes it necessary that the unit be air-conditioned and humidity-controlled. Of course, air-conditioning is desirable in an operating room or a recovery unit, anyhow.

The recovery unit is directly in continuity with the operating room suite, and patients are brought from their rooms through a very short stretch of corridor into the recovery unit. The more intimately the recovery room is in contact with the operating room, the shorter the trip will be, the better liaison there will be between the O.R. and the recovery unit, the greater the availability of doctors at all times for the recovery unit.

Beds used in the recovery unit are taken to the operating room. The patient is lifted from the operating room table to the recovery unit bed. There is no intermediary stretcher.

The blood bank is part of this same suite. Directly across the corridor, a very short distance away, are the hospital pharmacy, the x-ray department, and central supply.

If you can organize a concentration of your basic patient care facilities to this extent, you will minimize problems that might arise and have a very smoothly operating area.

There is a waiting room in which relatives of patients can sit and wait for bulletins about the patients in the unit. When patients stay in the unit for any length of time, we permit one relative to visit the patient—not one relative at a time, but only one relative, no matter how long the patient stays there. That relative may come in and out and stay for a minute or so.

We're in the process of growing out of the recovery unit by taking over this room and expanding our facilities, so that we will have, in addition to an eight-bed unit with a nurse's station, facilities for six or even eight or 10 additional patients, who will be short-term patients.

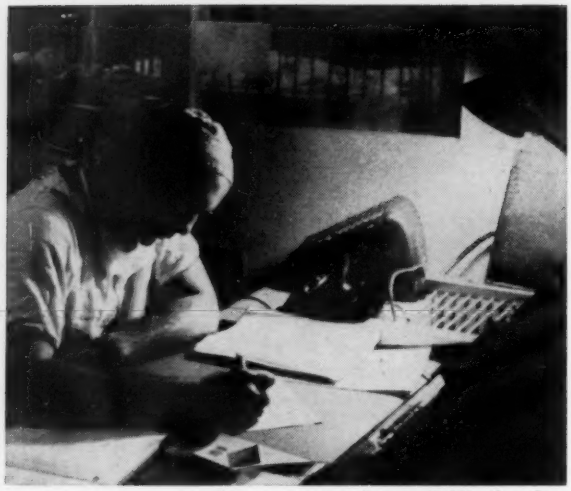
The next question is "HOW is such a recovery unit run? How is it staffed? How is it equipped? How are its daily functions carried out?"

The recovery unit should be staffed by a permanent group of nurses, just as the operating room is staffed by permanent operating room nurses. They shouldn't be girls who are pre-empted from one floor or another at odd times, disrupting patient care in other areas of the hospital. They should be a team of girls employed for this purpose, with a graduate registered nurse in charge, and as many other graduate registered nurses as can be corralled to make up the rest of the staff.

(Continued on next page)

Below: Patient is received in unit. Doors are wide enough to permit beds to enter with ease. Bed has no side rails. Blood transfusion is running. Notice that patient's head is on the far wall, so that all patients will be facing nurse sitting outside in the center.

Picture courtesy Parade Publication, Inc.



Picture courtesy Parade Publication, Inc.

Left: As patient is brought into the recovery unit, member of the resident staff comes in and writes the orders and transmits them to nurse in charge, so that there's no gap in this transition. Under gooseneck lamp is recessed chart rack, where all patient charts are kept while patients are in the unit. There is no special recovery room chart. Unit does have recovery room records, which become an integral part of patient's record when he is transferred from the unit. There are two telephones in the unit—a conventional one, in front of chart rack, so that nurse can call out for help whenever she wants to, and a second phone, with no dial, labeled, "Emergency Only." Recovery unit nurse can pick up this phone at any time, get the hospital operator, and get anything she wants in a hurry. In background are cubicles in which pediatric patients are kept.

RECOVERY ROOM continued

The unit should be controlled from a nursing point of view, we believe, not by the operating room supervisor, but by the nursing office, under the direct supervision of the surgical supervisor, who is in charge of the rest of surgical patient care in the hospital.

The liaison between the operating room supervisor and the recovery unit supervisor has to be very close. The operating room supervisor notifies the recovery unit supervisor when a patient is about ready to be transferred to the unit, but that is not as formidable as it sounds, because these girls are working in offices right next to each other. It's essential that this liaison be of the closest, because the flow of traffic at times can reach peak loads when the recovery unit is jammed, when transfers have to be made out in order to receive patients coming in. In many hospitals the recovery room actually functions under the supervision of the operating room supervisor, and this system probably works very well.

Professionally, the recovery unit is administratively under the direction of the chief of the surgical division, in whose department the anesthetists also function. No patient can leave our recovery unit until he is signed out in a book by a member of the surgical or anesthesia staffs.

A question that is always asked is "What is the cost of running a recovery unit—the cost to the hospital, the cost to the patient?" At our hospital ward service patients are not charged for the recovery unit, just as they are not charged for the operating room.

Private patients with their own private duty nurses are not charged for the recovery unit. They simply pay for their specials, who take care of them in the recovery unit under the supervision of the unit's supervisor.

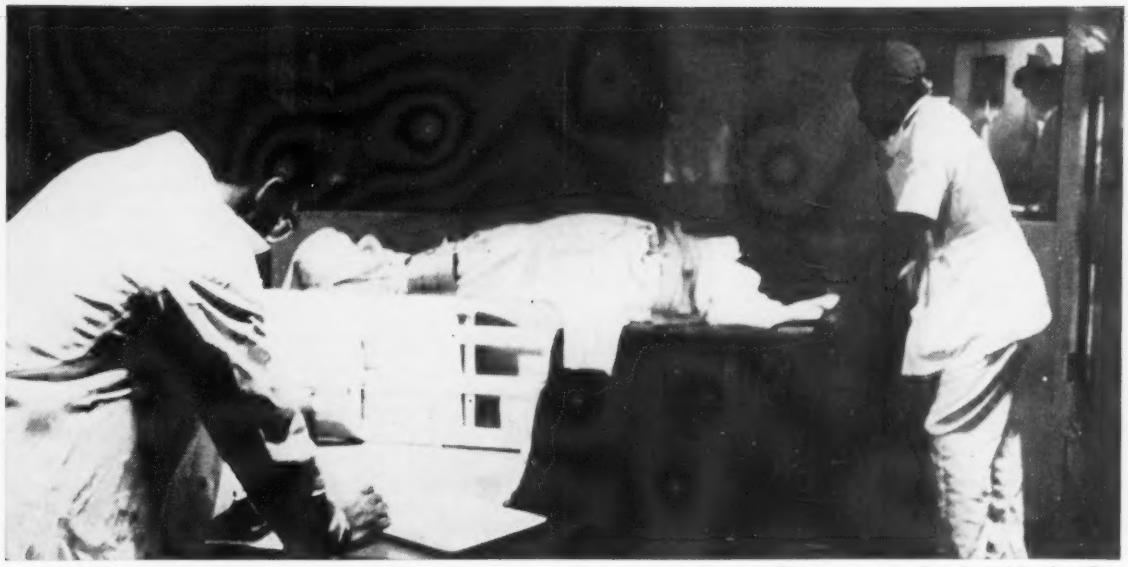
For semi-private or private patients without special duty nurses (the category in which most of our patients belong), there is a charge of approximately $1.50 an hour while the patient is in the recovery unit. The insurance programs do not cover this. At the end of each month the hospital may be $5 ahead or $5 behind, but I think most hospitals can absorb this budget item.

The next question is "WHO should go into the recovery unit?" We believe that all patients, whether they've had general anesthesia or spinal anesthesia, should go into the recovery unit until they have reacted, until they've stabilized as far as pulse, blood pressure, and respiration are concerned, to the extent that most of them have received their first postoperative sedation before they are transferred out.

Length of stay can vary tremendously in time, ranging from a half hour or an hour for short-term patients to at least overnight for most of our chest cases and all of our cardiac cases. Cases have been kept in the recovery unit for as long as six or seven days when they've been in critical condition and the services of the recovery unit or the operating room might be needed at any time.

Once you set up the unit on this principle, you no longer have strictly a recovery unit, you no longer have strictly a postanesthesia unit—you have a combination of recovery, postanesthesia, and group nursing all rolled into one. This is the reason we have had to expand our present facilities, taking over the additional room, where we will not put cubicles, but have curtains in tracks separating six, eight, or 10 bed stretchers where the short-term patients, who will be known to be fit for transfer within an hour or two, will go during the immediate recovery phase. This room will be more truly a postanesthesia room.

Below: Utility room in unit includes Executone which is turned on. Bed pan sterilizer is also included in this room.



Picture courtesy Parade Publication, Inc.

Above: Patient is being transferred out of unit. Dr. Hurwitt signs him out in the book as orderly wheels him away.

How long a patient should remain in the recovery suite is really a personal question. It has been suggested that as a rule a patient should be in the recovery unit as long as he's been in the operating room, but the length of time will vary tremendously with the type of case load in your particular hospital. Where a great deal of intracranial and intrathoracic surgery is done, patients will have to remain in the recovery suite longer.

When the bulk of your patients are short-term elective surgical material—gynecological, hernia, and gallbladder patients, for instance—obviously the stay will be much shorter. But to predicate a stay based on the time in the operating room would be extremely fallacious, as illustrated by a recent situation in our hospital.

I was doing a mitral commissurotomy in one room; a lobectomy for tuberculosis was going on in another room, and in the third room was a patient scheduled for a pneumonectomy for carcinoma of the lung. The pneumonectomy turned out to be inoperable. The lobectomy took between six and eight hours, and the patient with the mitral valvular lesion was out of the operating room in less than an hour. But that patient was in no shape to be moved from the recovery suite in an hour, or even two hours, because all these patients have under-water drainage tubes. We take portable x-rays in the recovery unit on all of them the next day. So they all have to stay overnight. Therefore, the length of time in surgery really has little relationship to the time in the recovery suite.

The last question is "HOW BIG should a recovery unit be?" The Public Health Service states that in hospitals having four or more operating rooms, there should be as many beds in the recovery unit as there are operating rooms, plus one, or plus two.

Detailed lists of supplies, equipment, spatial requirements, organization, and fine technical details you might need to know, were given by the Public Health Service in the November, 1952 issue of **Hospitals.** I recommend that article as a primer in recovery suite organization.

John Thompson, assistant director, Montefiore Hospital, New York City, who has been in charge of our recovery suite and operating room suite since it was reorganized, will be happy to answer any inquiries.

In July, 1954, Parade Magazine, a Sunday supplement syndicated throughout the country, published a study of our recovery suite, including some excellent photographs. This article should be available in your local libraries.

Below: Blanket-warming closet in utility room. Patients are covered with warm blankets as soon as they're brought into the unit.

Picture courtesy Parade Publication, Inc.

The O.R. Problem Clinic

by EDITH DEE HALL, R.N.

Mechanical Unit Aids in Hypothermia and Hyperthermia

● Operating room nurses welcome new equipment that is beneficial to the patient and helpful in eliminating some of the demands upon nurses' time and energy. This is true of a mechanical unit which was originally designed to replace hot-water bottles and ice bags but which has initiated many new developments through intensive scientific research.

The mechanical unit is designed to provide a wide range of thermostatically controlled body temperatures. It has been used to reduce high temperatures in the acutely ill preoperative patient, to prevent heat retention during surgery, and to treat hyperpyrexia due to infection and other causes. The unit may be used to provide local refrigeration for amputations and also for the preservation of limbs for long or short periods. This preservation is valuable in allowing time to treat the patient for shock and take supportive measures to build up strength for surgery, following traumatic injuries. As an anesthetic agent, hypothermia is applied in conjunction with drugs and has had some use in general and neurosurgery.

Although the use of hypothermia in cardiovascular surgery is not widespread, it has been used successfully on selective cases. The relative simplicity of the technic is an advantage. Enough anesthesia is given to prevent shivering and to keep the patient comfortable. By lowering the body temperature, oxygen requirements are reduced so that total vascular occlusion at the heart may be sustained long enough to perform deliberate anatomically precise operations within the heart. With hypothermia all circulation including the coronary flow is stopped while the heart is open. When the surgeon is sewing up, hyperthermia is started.

Hyperthermia provides a method for the medical application of heat and may be used following hypothermia to restore normal body temperature. Restoration, by means of thermostatic control, may take place as gradually or as quickly as the surgeon desires. The procedure is simple, and the chosen temperature may be maintained at a constant level.

The cabinet of the hypothermia-hyperthermia unit contains a motor-driven pump, a tank and coil for the refrigerant solution, and a condenser and heater which are controlled by a thermostat. The temperature of the solution can be raised, lowered, or maintained at any given point, and can be clinically applied to the patient. The pressure gauge, controls, and thermometer are mounted on top and are simple to operate. The refrigerant solution is circulated through rubber tubing channeled between layers of rubberized fabric which is made into blankets. A complete circulation of the refrigerant solution takes place approximately every 30 seconds. A continuous record of body temperature is maintained by use of a nasal or rectal type thermometer. The blankets or applicators come in various sizes and shapes for convenience and efficiency in applying externally the desired temperature to the whole body or to any part. They are flexible and therefore conform to the contour of the patient's body.

During surgery the unit is the responsibility of the anesthesiologist, who with the surgeon determines how it will be used and the exact procedure. After surgery it may be the responsibility of a nurse to care for the equipment. The blankets should be disconnected and cleaned. Since they are rubberized on both sides, this can be done by

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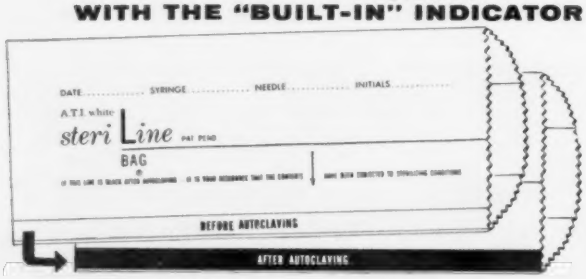

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sponging with an antiseptic soap solution. They should then be wiped dry and powdered lightly. Routine care should be given the machine so that it is always in good order.

A great amount of research is being done in the use of cold in medicine and surgery. New technics are being tried in laboratories, and as progress is made new mechanical devices will be designed. When new developments affect the surgical patient, operating room nurses co-operate by helping doctors improve procedures.

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NEW TRENDS IN SURGERY

(Continued from page 69)

made to keep it that way. If it is taken under unsterile conditions it is sterilized by radiation or by various other agents, such as ethylene oxide or betapropiolactone. Some have used simple 70 percent alcohol.

The graft may be preserved by freezing rather than by keeping it in nutrient media. When one freezes the graft very rapidly to avoid damaging it, he may then dry it by sucking off all the moisture in a vacuum. This freeze-dried graft may then be kept in a sealed tube for a long period of time, up to several years. When the graft is needed, it is removed in its dry state and dropped into saline solution for perhaps half an hour. It is then pliable, flexible, and very similar to the blood vessel in its original state.

Starting from the premise that one might use a blood vessel which was completely inert and nonviable since it had been sterilized and dried, the idea was gradually developed of employing something completely inert, such as cloth. Dr. Blakemore employed cloth made of vinyon-N which ordinarily permitted oozing of a small amount of blood through the pores, but this soon stopped and the cloth tube then functioned as a conduit, which is about all that the preserved blood vessels did. The blood vessels have the advantage of elasticity, but this does not appear to be particularly important when only a small segment of the vessel is replaced.

From the use of vinyon we have progressed to nylon, orlon, dacron, and a variety of other materials, so that surgeons now have available tubes of cloth which can be sewed on the spot by hand or by machine or woven in a special fashion to present seams and wrinkles. These inert materials and various plastic substitutes can be used also in replacing defects in the walls of the heart and various other organs, but the exact place of such prostheses is still being evaluated.

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Executive Housekeepers Meet in Philadelphia

The National Executive Housekeepers' Association, eastern district meeting, was held June 2-4, in the Warwick Hotel, Philadelphia, Pa.

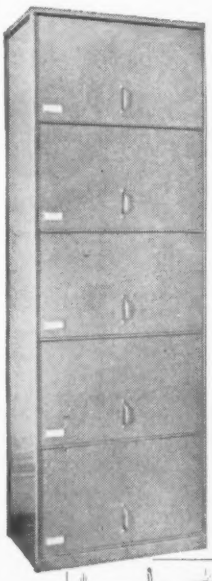
A special feature of the program was a panel discussion of hospital housekeeping problems, moderated by Emma Morgan, District of Columbia Hospital, Washington, D.C. Other members of the panel were: Mrs. Amy Delong, Passaic (N.J.) General Hospital; Mrs. E. Marie Hawley, Rochester (N.Y.) General Hospital; and Mrs. Elizabeth M. Tucker, West Haven (Conn.) Veteran's Hospital.

Library Pharmaceutical Section Elects Officers

At the recent convention of the pharmaceutical section, special libraries association, the following officers were elected: Jewell Maurice, assistant librarian, Eli Lilly and Co., chairman; James Olsen, librarian, Smith, Kline and French Laboratories, vice chairman; Wilma Kujawski, Distillation Products, secretary; and Frances Stratton, Lederle Laboratories, treasurer.

Geisinger Hospital to Train Anesthetists

A school for training nurse anesthetists will be inaugurated at the Geisinger Memorial Hospital, Danville, Pa. The course is fully approved by the American Association of Nurse Anesthetists, and will be under the supervision of J. M. Schaub, M. D., chief, department of anesthesiology, and his associate, W. D. Bauer, Jr., M. D.



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D. "AMP-O-VAC", REUSABLE AMPOULE: Permits withdrawal of novocaine, other medications, without exposing balance of contents to air. Hermetic closures, especially designed for puncture-sealing withdrawal, may be repeatedly sterilized and re-used. Sizes of 75 ml. to 150 ml.

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Central Supply Room Staff

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Up-To-Date Central Supply Equipment Cuts Hospital's Labor Costs

By Frank Harper

• The central service department in the Donald N. Sharp Community Hospital, San Diego, has enough up-to-date equipment so that only one-half of the usual amount of employees in a department of its kind have been employed.

One person can operate six machines simultaneously because of automatic and control devices on the equipment, according to Mrs. Marie Manderson, central service director.

"Because of this equipment we have employed only eight people in the entire department, while other hospitals normally would need at least twice that number for the same type of coverage," Mrs. Manderson says.

The $4,500,000 hospital, which was under construction for nearly two years, admitted its first patient April 24. Sharp Hospital is about nine miles north of downtown San Diego.

Central service uses the hospital's intricate system of two miles of pneumatic tubing for whisking messages, charges, and small articles to 30 sending and receiving stations throughout the nine-floor building.

Messages are sent in transparent plastic carriers, four inches in diameter and a foot long, from central service on the third floor to a re-routing station on the first floor. The re-routing operator then shoots the carriers to specified departments.

When a carrier reaches a department, a red light by the tube outlet flashes, and the carrier may be picked up by simply opening a small trap door. There are separate outlets, one for sending and one for receiving.

Although this system cost $30,000, Superintendent Frank R. McDougall says it will pay for itself in a few years by saving labor costs of messenger services and increasing the hospital's speed and efficiency.

Central service sends expendable and sterile goods to the various floors and the laboratory on two heavy-duty dumb waiters.

Many practical precautions have been taken in the construction of the department. All corners in the tiled work area are rounded and capped with a polished steel facing. Storage and work cabinets are made of birch and covered in a natural-finish, acid-resistant lacquer. The birch cabinets show no fingerprints.

All light switches and wall plugs have shockproof plates, and every electrical device that is plugged in is automatically grounded.

Central service employees work under ideal conditions. Indirect lighting, along with yellow walls and ceilings and the pale green tile in the work area, give a clean, soothing atmosphere. Cool air from one of the hospital's air filtering machines is piped into the room.

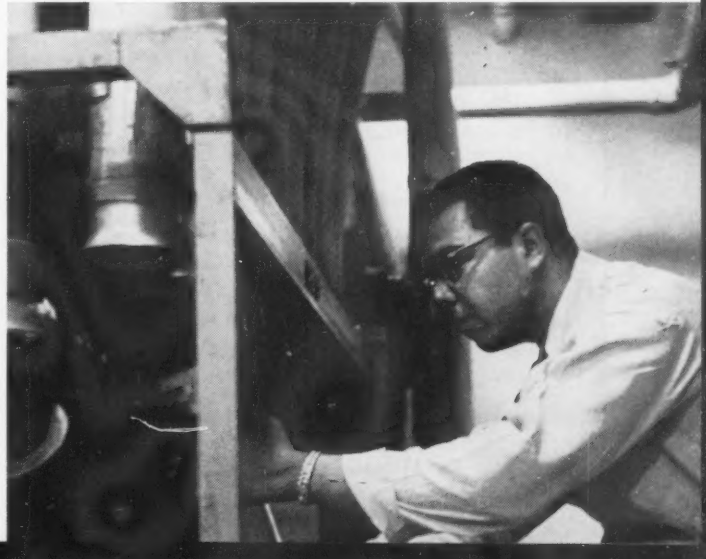
The room, 16 feet wide by 60 feet long, is partitioned to leave nine feet for the flasking area.

Storage cupboards for sterile supplies and trays are set up in islands to accommodate other departments.

Central service adjoins the x-ray department and the surgical suite.

Below: Mrs. Mary Bratt, L.V.N. sends a message down a pneumatic tube from the central service department on the third floor. Note transparent plastic carrier.

Below: Mrs. Bratt's message goes to this re-routing station where Eddie Rosa, distributor, notes the department it is being sent to, and places it in another carrier that shoots it to its destination.



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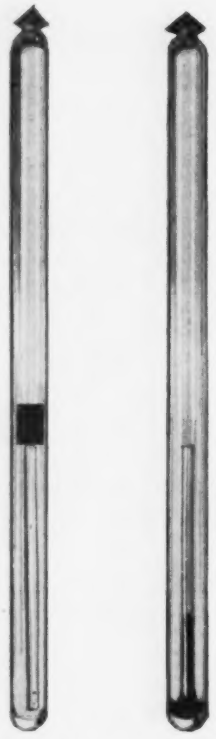

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Function, not Beauty, Important in Central Supply Room Design

By Frederick E. Markus*

● The design of central supply rooms has of late received considerable attention as a hospital area in which industrial methods of production and assembly can be employed advantageously. Despite this, many poor layouts result. This can be traced to the use of a few superficial concepts of what makes for efficient production.

Chief among these is the so-called "straight line flow" concept, based on the assumption that, ideally, supplies and materials are received at one end of an elongated area and a finished product is delivered at the opposite end. Even in industry, this simple concept does not always apply. The main line of flow can take the form of a loop and be just as efficient as a straight line. On somewhat the same premise, the work is assumed to move through a series of rooms along an assumed line of flow.

While flow as such is still an important aspect of any good planning, in any CSR the proper interrelationship of work stations is a much more important item. Consider first that there will be substantially more work stations than workers. In planning, these stations should be precisely spotted, allowing the proper work area and facilities for each. They should be arranged for sitting if possible, or alternate sitting and standing, or just standing—whatever best meets the work conditions and the workers' comfort. Provisions should be made for knee space and foot rests for those sitting and using high stools.

Of these stations, few will be full-time for any particular job. Therefore, the work station must be designed for dual use, or the worker must be able to circulate between respective stations without too great a loss in time. For example: Receiving is a work station, issuing is another. To put them at opposite ends of a long room, remote from any other work station, rises a question of who will man them. Both are bound to call for intermittent service. Actually, the two activities are generally better if adjacent and centrally located. Even then the combination may still not be a full-time job for anyone, but being nearer to other work stations it can more readily be combined with a third job.

This brings to light a second important aspect of CSR planning. Because of the short runs and the variety of work to be performed, the supervisor, who will most often perform a certain amount of production work, must be so located that from her own activities she can oversee her entire domain. Departmentalizing by means of room partitions or even alcoves is, for most operations, not warranted. Any process which is out of sight increases the task of supervision.

This problem was well illustrated in a visit to a new CSR of a large hospital. The supervisor was much distressed, actually frustrated by the difficulty of operating her department. As she put it, "Everything is in exactly the wrong place." It was also assumed that everybody would work standing. This is hardly humane. Stools were provided, but there was no knee space at any of the stainless steel work benches. So a sort of side-saddle posture was the only alternative.

With everything built in and the dominant materials ceramic tile and stainless steel, built to last forever, the prospects for altering this condition are remote.

A supervisor who is stuck with one of these rigid and inflexible departments has, unfortunately, little chance of ever getting corrections

*Mr. Markus, of the firm of Markus & Nocka, architects and engineers, Boston, has done extensive studies in work simplification and time and motion.

made. If there is excess open floor space, supplementary tables might be a partial solution. These can be arranged to suit job-to-job requirements.

For those who are interested in producing the utmost in efficiency, proper planning may be considered about half the battle. Substantial additional gains in efficient operation are possible by a study of methods and work measurement. From a pilot study just completed it is evident there remains much that can be done. Chiefly (although we admit we are oversimplifying somewhat), consider the following three questions with respect to each job:

1. How should this specific job be done?
2. Who should do it?
3. How long should this doing take?

Simple as these questions are, they are difficult for the untrained to answer. Yet answers are possible, and they are loaded with surprises.

The value of the answers, if they were known, is obvious. By simply adding up the total for No. 3 and dividing by eight (hours in a working day) the number of employees to run the department would be precisely known, after the usual allowance for personnel and breakdown time was made.

Few realize the potential economies in this field. Let us review one typical example—which turned out to be only a five-hour job instead of the eight-hour job it was previously assumed to be. No one had even suspected this.

Moreover, when an improved method was developed which eliminated much wasted motions, the job was reduced to three hours daily. Over and above this gain was the fact that the comfort of the worker was improved and interest in work improvement aroused in the department as a whole.

Unfortunately, supervisors are not equipped by training to make such studies. But just knowing and believing that few jobs as such could survive an analytic challenge without having their time cut substantially should sharpen a supervisor's scrutiny.

Nine-Month Course for Limb and Brace Makers

A course to train limb and brace makers will be sponsored by the Institute for the Crippled and Disabled, New York City. The nine-month course was created to meet the critical world shortage of such craftsmen.

Twelve students will be trained in the first course which begins September 12.

Radiation Grant Handed to City of Hope Medical Institute

The United States Atomic Energy Commission has awarded a financial grant to the City of Hope Medical Research Institute, Duarte, Calif., for a three-year study of the effects of radiation on living organisms.

Approximately $8,500 is involved for each year of the research program. The study will be headed by William D. Kaplan, M.D., chairman, department of genetics.

Twenty-Fifth Anniversary of Hospital Business Manager

A white anniversary cake which represented an administrator's desk, complete with silver telephone, memo pad, and a bouquet of flowers marked the 25th anniversary of Francis J. Bath, business manager, at Creighton Memorial St. Joseph's Hospital, Omaha.

Mr. Bath was the first business manager for the Sisters of St. Francis order.

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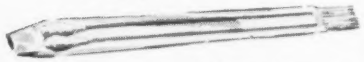

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6 cans—$4.80 each 12 cans—$4.60 each

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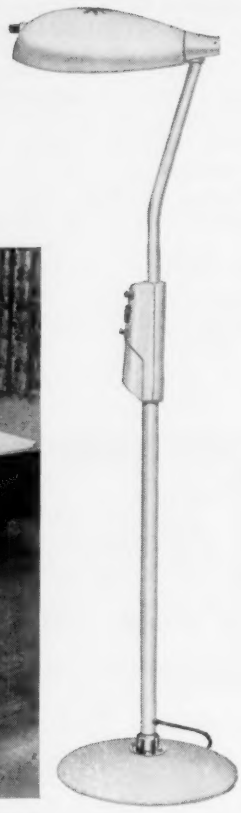

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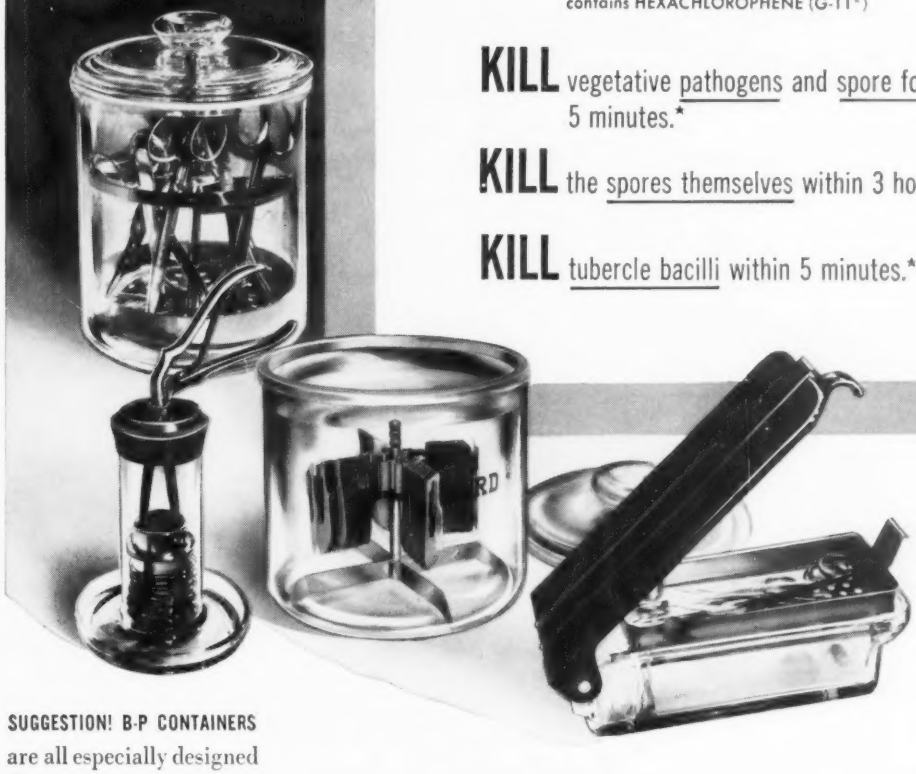

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